

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

12036

12060

CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY ALLEGANY		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CUMBERLAND		c. LENGTH OF STAY IN 1b 24	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION SACRED HEART		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> d. STREET ADDRESS 35 ORCHARD STREET	
3. NAME OF DECEASED (Type or print) HERBERT	First P.	Middle AMBROSE	Last 11
4. DATE OF DEATH 12-9-94	Month 11	Day 1	Year 1960
5. SEX MALE	6. COLOR OR RACE WHITE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 12-9-94
9. AGE (In years last birthday) 65 yrs.	10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Carman	10b. KIND OF BUSINESS OR INDUSTRY B. and O. R.R.	11. BIRTHPLACE (State or foreign country) Virginia
12. CITIZEN OF WHAT COUNTRY? USA		13. FATHER'S NAME JOHN WESLEY AMBROSE (D)	
14. MOTHER'S MAIDEN NAME MINNIE LEE AMBROSE		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) If yes, give war or dates of service)	
16. SOCIAL SECURITY NO.		17. INFORMANT PT'S CHART	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 420.0 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) arteriosclerotic heart disease (c) generalized arteriosclerosis		INTERVAL BETWEEN ONSET AND DEATH 6 yrs	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) after amputation of right leg (and thigh) on account of gangrene		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18) at the time of amputation of right leg (and thigh) on account of gangrene	
20c. TIME OF INJURY Hour a. m. p. m.	Month 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from 3-2 1959 to 11-1 1960 , that (I) (we) last saw the deceased alive on 11-1 1960 and that death occurred at 60 M , from the causes and on the date stated above.		22a. SIGNATURE L. Brings	
22c. PHYSICIAN'S NAME (Type) L. BRINGS		22b. DATE SIGNED 22d. ADDRESS 57 Greene Street, Cumberland, Md.	
23a. BURIAL, CREMATION OR REMOVAL (Specify) Burial	23b. DATE THEREOF 4 Nov 1960	23c. NAME OF CEMETERY OR CREMATORIUM Queens Point	23d. LOCATION (City, town, or county) (State) Keyser, W. Va.
24. FUNERAL DIRECTOR'S SIGNATURE Allen M. Rotnick		ADDRESS Keyser, W. Va.	25a. REC'D BY REGISTRAR DATE NOV 7 '60
			25b. REGISTRAR'S SIGNATURE Arthur S. Kraus

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/59

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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

12037

Reg. Dist. No.

12061				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) W. VA			
1. PLACE OF DEATH a. COUNTY ALLEGANY		b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cumberland		c. LENGTH OF STAY IN 1b 2 HRS. 40 MIN		d. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) ANTOCH, W. VA	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) MEMORIAL HOSPITAL MEMORIAL & WARWICK AVE.		e. STREET ADDRESS Rural		d. STREET ADDRESS Rural		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) EDGAR		First EDGAR		Middle LEE		Last BERG	
4. DATE OF DEATH NOVEMBER 25 1960		5. SEX MALE		6. COLOR OR RACE WHITE		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> 8. DATE OF BIRTH WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> SEPTEMBER 25, 1888 9. AGE (In years last birthday) 72 yrs.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Farmer		10b. KIND OF BUSINESS OR INDUSTRY Self		11. BIRTHPLACE (State or foreign country) MAYSVILLE, W. VA		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME EDGAR L. BERG		14. MOTHER'S MAIDEN NAME FRANCES S. ROTRUCK		15. WAS DECEASED EVER IN U. S. ARMED FORCES? [Yes, no, or unknown] No		16. SOCIAL SECURITY NO. 17. INFORMANT MEMORIAL HOSPITAL, CUMBERLAND, MD.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CORONARY OCCLUSION 420 DUE TO CORONARY SCLEROSIS		Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b)		DUE TO (c)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and find that death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/>		ACTUAL SIGNATURE Benedict Skitarelic		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		DATE SIGNED NOV. 25, 1960	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 27 Nov 1960		22c. NAME OF CEMETERY OR CREMATORIAL Lahmansville		22d. LOCATION (City, town, or county) (State) Lahmansville, W. Va.	
23. FUNERAL DIRECTOR'S SIGNATURE Allen M. Rotruck		ADDRESS Keyser, W. Va.		24a. REC'D BY REGISTRAR NOV 28 '60		24b. REGISTRAR'S SIGNATURE Arthur L. Rotruck	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any detail is necessary, please execute the certificate, writing the word "Pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with Form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial permit. File Pages 1 and 2 with the registrar prior to burial, cremation, or removal.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending", in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

VS. A15ME(5)
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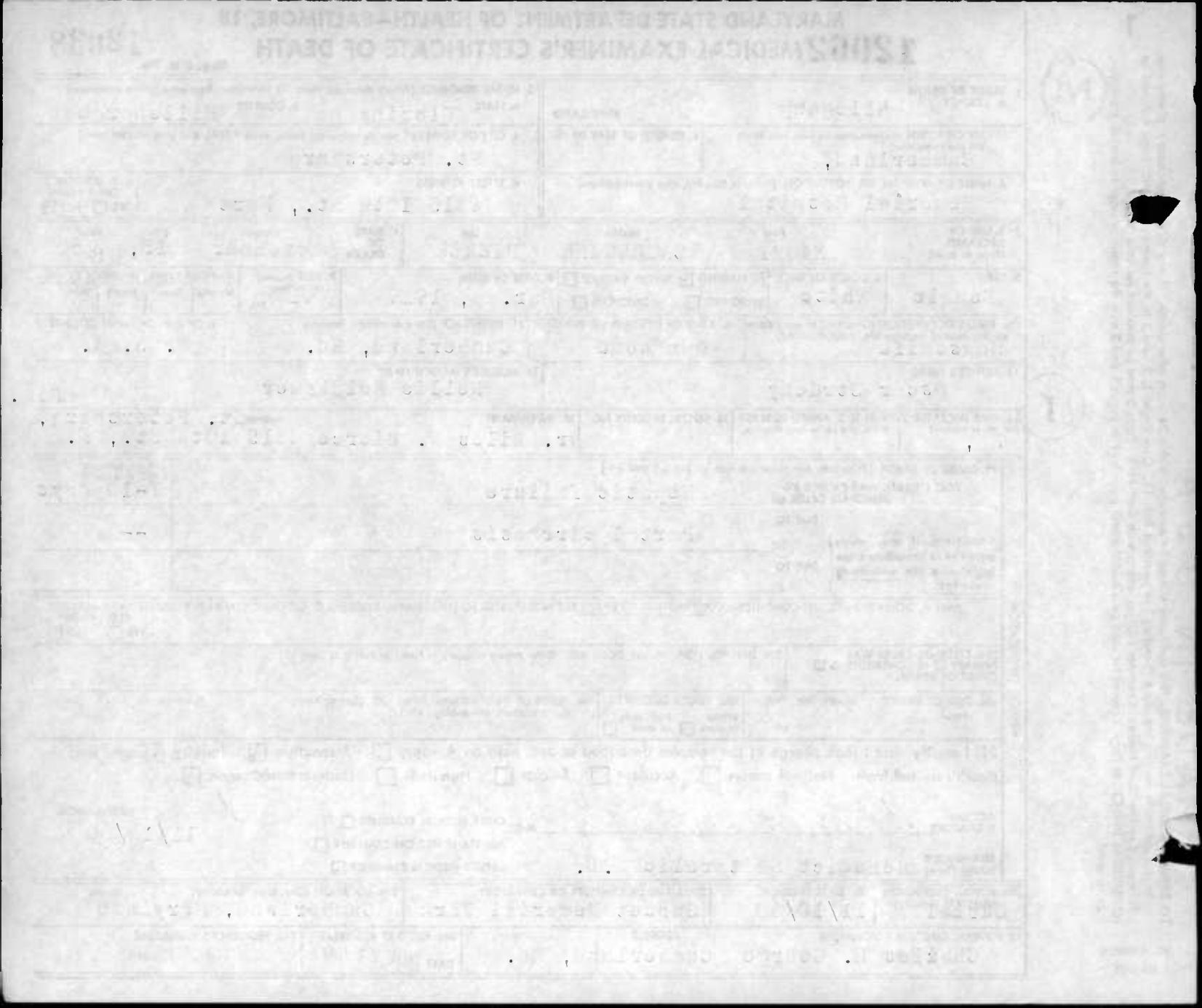
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MANAGAN STATE EXAMINER OF DEATH
SPECIAL EXAMINER OF DEATH



1 MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

12039

Reg. Dist. No.

12111					
1. PLACE OF DEATH a. COUNTY Allegany		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) b. STATE MARYLAND Maryland c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) La Vale La Vale			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) La Vale La Vale		c. LENGTH OF STAY IN 1b 3 Yrs. d. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 528 Mill Street 528 Mill Street			
3. NAME OF DECEASED (Type or print) GEORGE		First NMI	Middle BINGHAM		
4. DATE OF DEATH November 27, 1960		Lost Month Day Year			
S. SEX Male		6. COLOR OR RACE White			
7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>		8. DATE OF BIRTH March 24, 1869			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired Trainman		10b. KIND OF BUSINESS OR INDUSTRY B & O RR			
11. BIRTHPLACE (State or foreign country) Rainsburg, Pennsylvania		12. CITIZEN OF WHAT COUNTRY? USA			
13. FATHER'S NAME John Bingham		14. MOTHER'S MAIDEN NAME Susan Mowery			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. None			
17. INFORMANT Goldie B. Bingham		Address 528 Mill St., LaVale, Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]		INTERVAL BETWEEN ONSET AND DEATH 1-2 Hrs.			
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 540 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.		GASTRIC HEMORRHAGE			
DUE TO (b) Peptic Ulcer		***			
DUE TO (c)					
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>			
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and find that death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/>					
ACTUAL SIGNATURE Benedict Skitarelic		DATE SIGNED M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> November 28, 1960			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 11/30/60		22c. NAME OF CEMETERY OR CREMATORIUM Hillcrest Burial Park	
22d. LOCATION (City, town, or county) (State) Cumberland, Maryland					
23. FUNERAL DIRECTOR'S SIGNATURE John J. Hafer					
ADDRESS Cumberland, Maryland					
24a. REC'D BY REGISTRAR DEC 1 '60					
24b. REGISTRAR'S SIGNATURE John J. Hafer					

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any detail is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File Pages 1 and 2 with the registrar prior to burial or removal.

VS. AISMES(S)
SM 9/55

MISSOURI STATE DEPARTMENT OF HEALTH - DIVISION 11
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
 DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

12040

12063		Item 9 Form 6276 12-26-60			
1. PLACE OF DEATH a. COUNTY ALLEGANY		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE PENNSYLVANIA b. COUNTY BEDFORD			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CUMBERLAND		c. LENGTH OF STAY IN 1b 40 days		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) RURAL NEAR BEDFORD	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION SACRED HEART		d. STREET ADDRESS RT. 3,		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) OTIS		First W.	Middle BOOR	Last BOOR	4. DATE OF DEATH Month 11 Day 26 Year 1960
S. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	B. DATE OF BIRTH 11-7-31	9. AGE (In years last birthday) 29 yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer		10b. KIND OF BUSINESS OR INDUSTRY Odd Jobs & Gardner		11. BIRTHPLACE (State or foreign country) Bedford Valley Penna.	
13. FATHER'S NAME WILLIAM BOOR		14. MOTHER'S MAIDEN NAME CLARA SIMMONS BOOR		12. CITIZEN OF WHAT COUNTRY? USA	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. I 72-26-7893		17. INFORMANT PT'S CHART	Address
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]					
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 491X DUE TO Thermonia, streptococcal INTERVAL BETWEEN ONSET AND DEATH					
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO and monilial					
DUE TO (c)					
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)					
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) Centerville, Pa. (County) Centre Co. (State) Penna.					
21. I certify that (I) (this hospital) attended the deceased from Oct. 12 1960, to Nov. 26 1960, that (I) (we) last saw the deceased alive on Nov. 26 1960 and that death occurred at 520p from the causes and on the date stated above.					
22a. SIGNATURE Leo H. Ley Jr.		M.D. <input type="checkbox"/> ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>	22b. DATE SIGNED 11/28/60		
22c. PHYSICIAN'S NAME (Type) LEO H. LEY, M.D.		22d. ADDRESS 456 N. CENTER ST.			
23a. BURIAL, CREMATION OR REMOVAL (Specify) Burial		23b. DATE THEREOF 11-29-60		23c. NAME OF CEMETERY OR CREMATORIAL Fellowship Cem.	
23d. LOCATION (City, town, or county) Centerville, Pa. (State) Penna.					
24. FUNERAL DIRECTOR'S SIGNATURE James F. Scarpelli		ADDRESS Cumberland, Md.		25a. REC'D BY REGISTRAR DATE NOV 29 '60	
25b. REGISTRAR'S SIGNATURE Arthur S. Kraus					

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4
 may be retained by the hospital or attending physician and completely filled in by the funeral director.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
 DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

12064

CERTIFICATE OF DEATH

12041

1. PLACE OF DEATH a. COUNTY ALLEGANY		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYL AND	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CUMBERLAND		c. LENGTH OF STAY IN 1b 2 DAYS	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION MEMORIAL HOSPITAL		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print)	First MARTIN	Middle Joseph	Last BREIGHNER
4. DATE OF DEATH	Month NOVEMBER	Day 23	Year 19 60
5. SEX MALE	6. COLOR OR RACE WHITE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH SEPT. 17, 1874
9. AGE (In years last birthday) 86	10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) RETIRED Machinist	11. KIND OF BUSINESS OR INDUSTRY B. & O. Rwy.	12. BIRTHPLACE (State or foreign country) MT. UNION, PA.
13. FATHER'S NAME JOSEPH M. BREIGHNER	14. MOTHER'S MAIDEN NAME Philomena SPAULDING		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No,	16. SOCIAL SECURITY NO.	17. INFORMANT	Address MEMORIAL HOSPITAL - CUMBERLAND, MARYLAND
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]			
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 420.1 Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. (b) DUE TO (c) DUE TO			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (o) 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			
20c. TIME OF INJURY Hour a. m. p. m.	20d. INJURY OCCURRED While at work <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
19			
21. I certify that (I) (this hospital) attended the deceased from Nov 20 , 1960, to Nov , 1960, that (I) (we) last saw the deceased alive on Nov 23 , 1960, and that death occurred at 6:30A M, from the causes and on the date stated above.			
22a. SIGNATURE <i>Philomena L. H.</i>		22b. DATE SIGNED <i>11/24/60</i>	
22c. PHYSICIAN'S NAME (Type) DR. O. G. HIMMELWRIGHT	M.D. <input checked="" type="checkbox"/> ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>	22d. ADDRESS <i>133 Va Ave, Cumberland, Md.</i>	
23a. BURIAL, CREMATION, REMAVAL (specify) BURIAL	23b. DATE THEREOF 11/25/60	23c. NAME OF CEMETERY OR CREMATORY Greenmount Cemetery	23d. LOCATION (City, town, or county) (State) Cumberland, Maryland
24. FUNERAL DIRECTOR'S SIGNATURE Charles L. George	ADDRESS Cumberland, Md.	25a. REC'D BY REGISTRAR DATE NOV 28 '60	25b. REGISTRAR'S SIGNATURE Arthur S. Kraus

WILSON, CALIFORNIA, 1911. 211

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12112 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No.

12642

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with Form PM3. Page 5 may be retained for your information.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

1. PLACE OF DEATH a. COUNTY Allegany		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE Maryland b. COUNTY Allegany	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural nr. Flintstone		c. LENGTH OF STAY IN 1b years	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Route 1, Flintstone		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) X Rural, nr. Flintstone	
3. NAME OF DECEASED (Type or print) ALLEN		4. DATE OF DEATH Last Month Day Year BROWNING November 10, 1960	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> 8. DATE OF BIRTH WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> February 10, 1889	9. AGE (in years last birthday yrs.) IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired Machinist		10b. KIND OF BUSINESS OR INDUSTRY Celanese Corporation	11. BIRTHPLACE (State or foreign country) Rt. 1, Flintstone, Md.
12. CITIZEN OF WHAT COUNTRY? USA		13. FATHER'S NAME Meshach Browning	
14. MOTHER'S MAIDEN NAME Cornelia Wilson		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No	
16. SOCIAL SECURITY NO.		17. INFORMANT Julia W. Browning, Indianapolis, Indiana	
Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]			
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Maceration of Brain</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause first. (b) <u>GUNSHOT WOUND</u> DUE TO (c)			
INTERVAL BETWEEN ONSET AND DEATH Sudden			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
19. WAS AUTOPSY PERFORMED? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Self inflicted gunshot wound	
20c. TIME OF INJURY Month, Day, Year Hour 9 a.m. Nov. 10 1960		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) At home
20f. (City or town) Rt. 1, Flintstone, Maryland		(County) (State)	
21. I certify that I took charge of the remains described above, held on Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and find that death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input checked="" type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/>			
ACTUAL SIGNATURE Benedict Skitarelic		DATE SIGNED November 10, 1960	
EXAMINER'S NAME (Type) BENEDICT SKITARELIC, M.D.		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Nov. 13, 1960	22c. NAME OF CEMETERY OR CREMATORIAL I.O.O.F. Cemetery
22d. LOCATION (City, town, or county) Rt. 1, Flintstone, Md.		(State)	
23. FUNERAL DIRECTOR'S SIGNATURE John J. Hafer, Cumberland, Maryland		24a. REC'D BY REGISTRAR NOV 14 '60	24b. REGISTRAR'S SIGNATURE Charles S. Kraus

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician and completely filled in by the funeral director.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

12043

12065

CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY ALLEGANY		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE MARYLAND	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CUMBERLAND		c. LENGTH OF STAY IN 1b 34 HOURS	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION SACRED HEART HOSPITAL		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) FROSTBURG	
3. NAME OF DECEASED (Type or print) HAROLD		d. STREET ADDRESS 150 MT. PLEASANT ST.	
4. DATE OF DEATH NOV. 3		Month	Day Year 19 60
S. SEX MALE	6. COLOR OR RACE WHITE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH MARCH 16, 1914
9. AGE (In years last birthday) 46 yrs.		10. IF UNDER 1 YEAR Months 0	11. IF UNDER 24 HRS. Hours 0
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) OWNER-MGR.		10b. KIND OF BUSINESS OR INDUSTRY wholesale egg business	
10c. BIRTHPLACE (State or foreign country) MARYLAND		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME ARTHUR CARPENTER		14. MOTHER'S MAIDEN NAME ROSE HAINES	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) NO		16. SOCIAL SECURITY NO. 213-22-4443	
17. INFORMANT PATIENTS CHART		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]			
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral vascular accident			
331X DUE TO			
Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. } (b) _____			
DUE TO (c) _____			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 10 - 5 19 60 to 11 - 3 19 60 , that (I) (we) last saw the deceased alive on 11 - 2 19 60 , and that death occurred at 4:35 PM , from the causes and on the date stated above.			
22a. SIGNATURE <i>George W. Ballin, M.D.</i>		22b. DATE SIGNED 10-3-60	
22c. PHYSICIAN'S NAME (Type) GEORGE W. BALLIN, M.D.		22d. ADDRESS 62 GREENE ST., CUMBERLAND, MD.	
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b. DATE THEREOF 11-5-60	
23c. NAME OF CEMETERY OR CREMATORIAL F' BG. MEMORIAL PARK		23d. LOCATION (City, town, or county) FROSTBURG, MD.	
24. FUNERAL DIRECTOR'S SIGNATURE <i>J. P. Durst</i>		25a. REC'D BY REGISTRAR NOV 7 '60	
		25b. REGISTRAR'S SIGNATURE <i>Arthur S. Kraus</i>	

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MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

12044

CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY ALLEGANY		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND		b. COUNTY ALLEGANY					
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CUMBERLAND		c. LENGTH OF STAY IN 1b 7 HOURS		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) OLDTOWN		d. STREET ADDRESS 1-					
d. NAME OF HOSPITAL (If not in hospital, give street address) MEMORIAL HOSPITAL, MEMORIAL AVENUE						e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print)		First CHARLES	Middle Hanely	Last CARTWRIGHT	4. DATE OF DEATH	Month NOVEMBER	Day 21	Year 19 60			
5. SEX MALE		6. COLOR OR RACE WHITE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH JULY 13, 1908		9. AGE (In years last birthday) 52 yrs.	10. IF UNDER 1 YEAR Months 0	11. IF UNDER 24 HRS. Days 0			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Foreman		10b. KIND OF BUSINESS OR INDUSTRY Kopper Co.		11. BIRTHPLACE (State or foreign country) OLDTOWN, MARYLAND		12. CITIZEN OF WHAT COUNTRY? U.S.A.					
13. FATHER'S NAME LEVI CARTWRIGHT				14. MOTHER'S MAIDEN NAME LULA GROSS		15. ADDRESS MEMORIAL HOSPITAL, CUMBERLAND, MARYLAND					
16. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		17. SOCIAL SECURITY NO. 232-10-5621		18. INFORMANT		19. INTERVAL BETWEEN ONSET AND DEATH 7 HRS					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 420.0		DUE TO Coronary occlusion		DUE TO Arterosclerotic Heart Disease		DUE TO Cardiac decompensation					
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.		(b)		(c)							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from _____ to _____, that (I) (we) last saw the deceased alive on _____, and that death occurred on _____ at _____ AM on the causes and on the date stated above.		22a. SIGNATURE George M. Simons		22b. DATE SIGNED 11/21/60							
22c. PHYSICIAN'S NAME (Type) DR. GEORGE M. SIMONS		22d. ADDRESS ALGONQUIN HOTEL, CUMBERLAND, MD.									
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF Nov. 23, 1960		23c. NAME OF CEMETERY OR CREMATORIAL ADDRESS Davis Memorial Cemetery		23d. LOCATION (City, town, or county) Cumberland, Md.		(State)			
24. FUNERAL DIRECTOR'S SIGNATURE Charles L. George, Cumberland, Md.				25a. REC'D. BY REGISTRAR NOV 28 '60		25b. REGISTRAR'S SIGNATURE Arthur S. Tamm					

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4
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page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
 DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

12067 12045

1. PLACE OF DEATH a. COUNTY ALLEGANY		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE WEST VIRGINIA		b. COUNTY HAMPSHIRE			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CUMBERLAND		c. LENGTH OF STAY IN 1b 27 DAYS		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) GREAT CAPON		d. STREET ADDRESS 85X3			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION MEMORIAL HOSPITAL MEMORIAL AVE.				d. STREET ADDRESS		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) OSCAR		First R.	Middle CATLETT	Last CATLETT	4. DATE OF DEATH NOVEMBER 8 1960	Month NOVEMBER	Day 8	Year 1960	
S. SEX MALE	6. COLOR OR RACE WHITE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH FEB. 10, 1890	9. AGE (In years last birthday) yrs. 70	IF UNDER 1 YEAR Months 0	IF UNDER 24 HRS. Hours 0	IF UNDER 24 HRS. Min. 0	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) VIRGINIA		12. CITIZEN OF WHAT COUNTRY? U. S. A.			
13. FATHER'S NAME BENJAMIN F. CATLETT				14. MOTHER'S MAIDEN NAME MARY JANE COROSEN					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO.		17. INFORMANT MEMORIAL HOSPITAL		Address CUMBERLAND, MD.			
18. CAUSE OF DEATH [Enter only one cause per line or (a), (b), and (c).]									
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 422.1 Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. (b) DUE TO (c) DUE TO PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <i>Pneumonia</i> <i>Emphysema</i> <i>Senile</i> <i>Pneumonia</i> <i>Fibrosis</i> <i>Bilateral</i> <i>atelectasis</i> <i>Cardio</i> <i>vascul</i> <i>ob</i> <i>dis</i> <i>Tracheotomy</i> <i>11-8-60.</i>									
INTERVAL BETWEEN ONSET AND DEATH									
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <i>10.12.1960 - 11-8-1960</i>		20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)	
21. I certify that (I) (<i>his hospital</i>) attended the deceased from <i>10.12.1960</i> to <i>11-8-1960</i> that (I) (<i>he</i>) last saw the deceased alive on <i>11-8-1960</i> and that death occurred at <i>7:00 PM</i> on the causes and on the date stated above.								19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
22a. SIGNATURE <i>M. L. Williams</i>		M.D.		ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <i>11-9-60</i>			
22c. PHYSICIAN'S NAME (Type) DR. W. F. WILLIAMS		22d. ADDRESS CUMBERLAND, MD.							
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b. DATE THEREOF 11/8/60		23c. NAME OF CEMETERY OR CREMATORIAL WESLEY CEM.		23d. LOCATION (City, town, or county) G. C. CROWSON, MORGAN W. Va.			
24. FUNERAL DIRECTOR'S SIGNATURE <i>Parke Johnson Co.</i>		ADDRESS <i>Buckley Spgs. W. Va.</i>		25a. REC'D BY REGISTRAR DATE NOV 14 '60		25b. REGISTRAR'S SIGNATURE <i>Arthur S. Kraus</i>			

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MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

12068			
1. PLACE OF DEATH a. COUNTY ALLEGANY		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CUMBERLAND		c. LENGTH OF STAY IN 1b 3 DAYS	
d. NAME OF HOSPITAL (Hospital, if any) MEMORIAL HOSPITAL OR INSTITUTION MEMORIAL & WARWICK AVES.,		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) CLARA		First Middle ELLEN	Last CRITCHFIELD
4. DATE OF DEATH NOVEMBER 26 1960	Month NOVEMBER	Day 26	Year 1960
5. SEX FEMALE	6. COLOR OR RACE WHITE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH NOV. 16, 1882
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Postmistress		10b. KIND OF BUSINESS OR INDUSTRY Civil Service	
11. BIRTHPLACE (State or foreign country) PENNSYLVANIA		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME JESSE CRITCHFIELD		14. MOTHER'S MAIDEN NAME REBECCA GESSNER	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No	16. SOCIAL SECURITY NO. None	17. INFORMANT MEMORIAL HOSPITAL	Address CUMBERLAND, MD.
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]			
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 420-1 Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. (b) <i>Congestive Heart Failure - acute</i> (c) <i>Chronic ASC VHD with myocardial and Coronary Insufficiency approx. 15 yrs.</i> approx. 12 hrs DUE TO Acute Central Nervous Accident with Right Sided Paralysis and complete motor palsies 11/23/60			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) 11/23	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m.	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 11/23	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from 11/23 1960 to 11/26 1960 , that (I) (we) last saw the deceased alive on 11/25 1960 , and that death occurred at 11/26 1960 from the causes and on the date stated above.			
22a. SIGNATURE John A. Topper		22b. DATE SIGNED 11/26/60	
22c. PHYSICIAN'S NAME (Type) JOHN A. TOPPER		22d. ADDRESS Hyndman Rd	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF Nov. 29, 1960	
24. FUNERAL DIRECTOR'S SIGNATURE Stanley J. Leigier		23c. NAME OF CEMETERY OR CREMATORIAL Rose Hill Cemetery	
ADDRESS Hyndman Rd		25a. REC'D BY REGISTRAR DATE NOV 30 '60	
25b. REGISTRAR'S SIGNATURE Arthur S. Knapp			

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4

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TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

12069 12047

1. PLACE OF DEATH a. COUNTY ALLEGANY		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE WEST VIRGINIA		b. COUNTY MINERAL	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CUMBERLAND		c. LENGTH OF STAY IN 1b 1 DAY		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) WILEY FORD		d. STREET ADDRESS 85X-3	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION MEMORIAL HOSPITAL				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print)	First FRANTIE	Middle M.	Last CROSS	4. DATE OF DEATH	Month NOVEMBER	Day 1	Year 19 60
S. SEX FEMALE	6. COLOR OR RACE WHITE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH MARCH 3, 1878	9. AGE (In years last birthday) 82 yrs.	IF UNDER 1 YEAR Months 0	IF UNDER 24 HRS. Hours 0	Min. 0
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country) PAW PAW, W.VA.	12. CITIZEN OF WHAT COUNTRY? U.S.A.				
13. FATHER'S NAME SAMUEL PRICE	14. MOTHER'S MAIDEN NAME MAGGIE MILES						
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No	16. SOCIAL SECURITY NO. None	17. INFORMANT MEMORIAL HOSPITAL - CUMBERLAND, MARYLAND	Address				
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 420.1 DUE TO Acute Myocardial & Coronary Disease INTERVAL BETWEEN ONSET AND DEATH 1960 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c)							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Anesthetic Hemorrhage - Diarrheal 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) 1960					
20c. TIME OF INJURY Hour o. m. p. m.	Month 19	Doy	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 1960	20f. (City or town) 1960	(County) 1960	(State) 1960
21. I certify that (I) (this hospital) attended the deceased from 11:00 A.M. 19 1960 , to 11:00 P.M. 19 1960 , that (I) (we) last saw the deceased alive on 1960 , and that death occurred at 11:00 P.M. from the causes and on the date stated above.							
22a. SIGNATURE R. J. Williams				M.D. <input type="checkbox"/> ATTENDING PHYS. 1960	MED. DIRECTOR <input type="checkbox"/>	STAFF PHYS. <input type="checkbox"/>	22b. DATE SIGNED 11/4/60
22c. PHYSICIAN'S NAME (Type) DR. R.J. WILLIAMS	22d. ADDRESS Cumberland Md						
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF 11/4/60	23c. NAME OF CEMETERY OR CREMATORIAL Rose Hill Cem.		23d. LOCATION (City, town, or county) Cumberland Md (State) 1960			
24. FUNERAL DIRECTOR'S SIGNATURE Louis J. Inc. Cumb. Md		ADDRESS		25a. REC'D BY REGISTRAR NOV 4 '60	25b. REGISTRAR'S SIGNATURE Arthur S. Kraus		

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

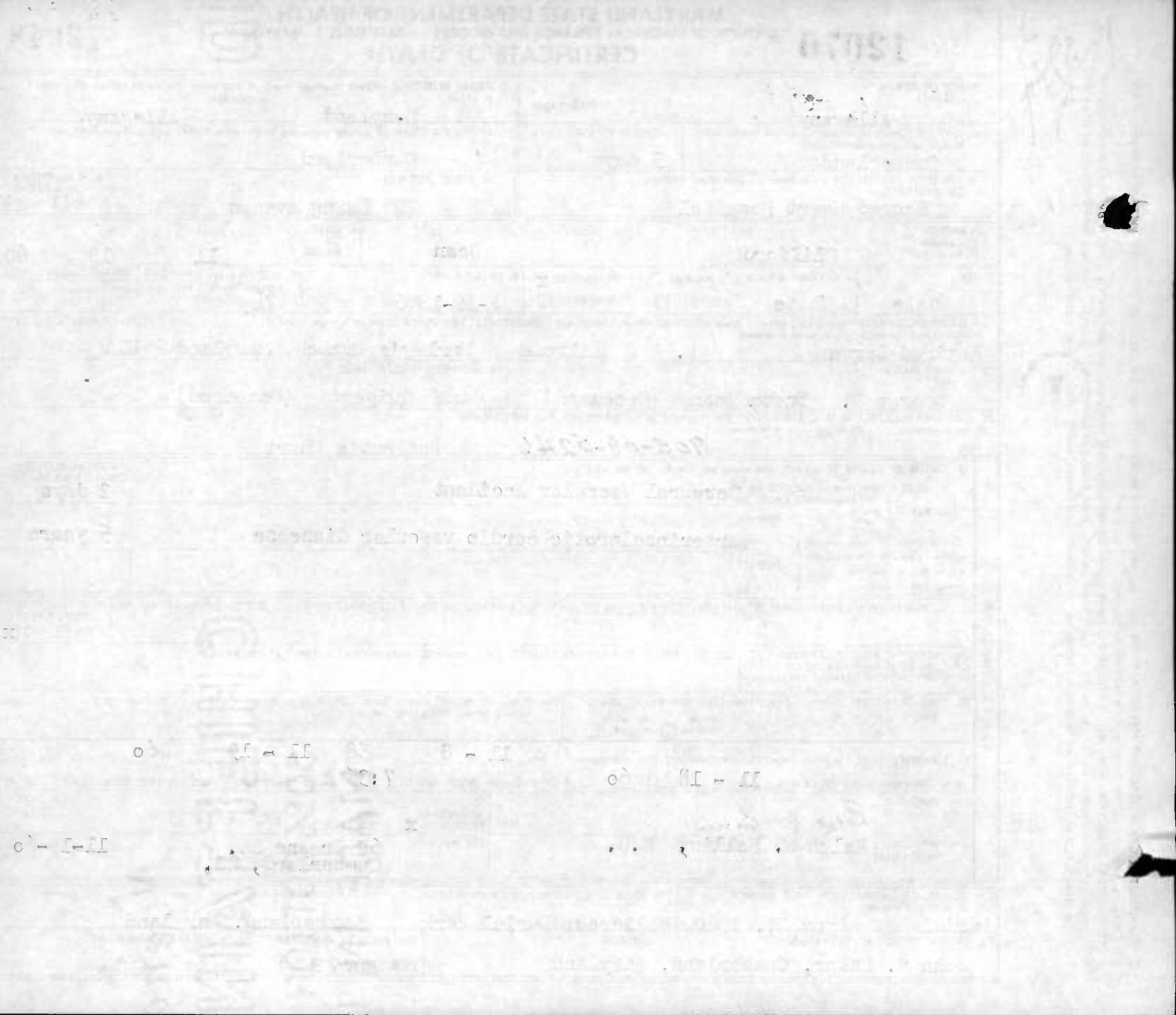
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HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician.

FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-in-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event within 72 hours of death.

1. PLACE OF DEATH a. COUNTY Allegany				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cumberland		c. LENGTH OF STAY IN 1b 3 days		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 02		Maryland	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Sacred Heart Hospital				d. STREET ADDRESS 208 Laing Avenue			
3. NAME OF DECEASED (Type or print) Clifford				First Clifford	Middle 	Last Dean	4. DATE OF DEATH 11 19 1960
S. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>	WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	B. DATE OF BIRTH 2-19-1886		9. AGE (In years lost birthday) 74	IF UNDER 1 YEAR IF UNDER 24 HRS. Months
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired Carman		10b. KIND OF BUSINESS OR INDUSTRY B. & O Railroad		11. BIRTHPLACE (State or foreign country) Murley's Branch, Maryland		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME George W. Enoch Dean (Deceased)				14. MOTHER'S MAIDEN NAME Sarah Swigert (Deceased)			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no				16. SOCIAL SECURITY NO. 705-09-5246			
17. INFORMANT				Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: Cerebral Vascular Accident INTERVAL BETWEEN IMMEDIATE CAUSE (a) 422.1 ONSET AND DEATH 2 days							
Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause lost. 				DUE TO (b) Arteriosclerotic cardio vascular disease 5 years			
DUE TO (c) 							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Hour o. m. p. m.	Month, Doy, Year 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) 	(County)	(State)	
21. I certify that (I) (this hospital) attended the deceased from 11-8 1958 to 11-19 1960 , that (I) (we) last saw the deceased alive on 11-18 1960 , and that death occurred at 7:35 A from the causes and on the date stated above.							
22a. SIGNATURE Ralph W. Balling				M.D.	ATTENDING PHYS. <input checked="" type="checkbox"/>	MED. DIRECTOR <input type="checkbox"/>	STAFF PHYS. <input type="checkbox"/>
22c. PHYSICIAN'S NAME (Type) Ralph W. Balling, M.D.				22d. ADDRESS 62 Greene St., Cumberland, Md.			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF Nov 21, 1960		23c. NAME OF CEMETERY OR CREMATORIAL Hillcrest Burial Park		23d. LOCATION (City, town, or county) Cumberland, Maryland	
24. FUNERAL DIRECTOR'S SIGNATURE John J. Hafer, Cumberland, Maryland				ADDRESS		25a. REC'D BY REGISTRAR NOV 22 '60	25b. REGISTRAR'S SIGNATURE Arthur S. Kimes



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

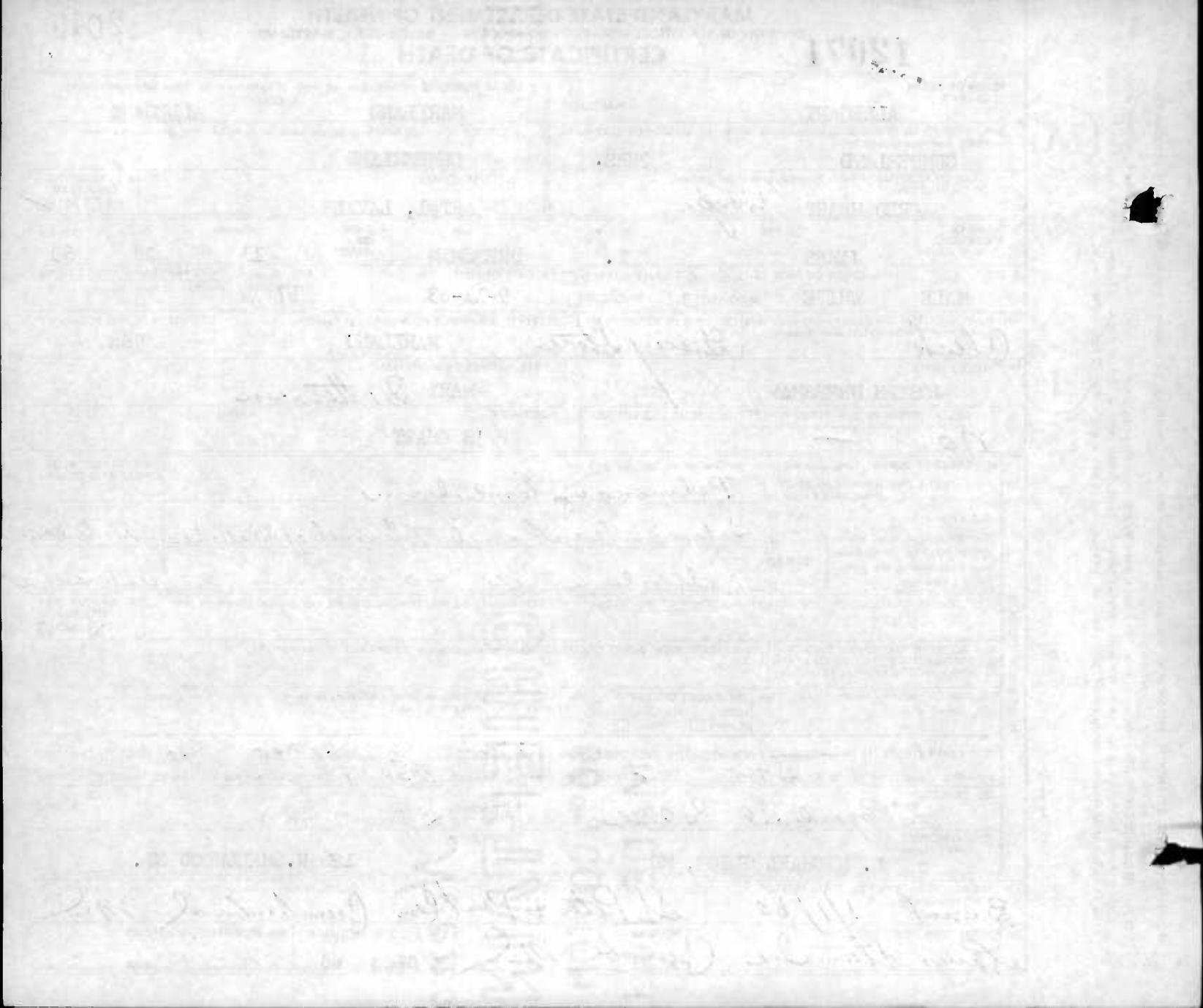
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

12071

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

12049

1. PLACE OF DEATH a. COUNTY ALLEGANY		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CUMBERLAND		c. LENGTH OF STAY IN 1b 2HRS.	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION SACRED HEART		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> d. STREET ADDRESS RT#1, LAVALE	
3. NAME OF DECEASED (Type or print) JAMES	First T.	Middle DRESSMAN	Last 11
4. DATE OF DEATH 28	Month 11	Day 28	Year 1960
S. SEX MALE	6. COLOR OR RACE WHITE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 9-11-03
9. AGE (In years last birthday) yrs. 57	10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Clerk	10b. KIND OF BUSINESS OR INDUSTRY Grocery Store	11. BIRTHPLACE (State or foreign country) MARYLAND
12. CITIZEN OF WHAT COUNTRY? USA			
13. FATHER'S NAME JOSEPH DRESSMAN		14. MOTHER'S MAIDEN NAME MARY Detterman	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. PT'S CHART	
17. INFORMANT		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]			
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Pulmonary Embolism			
DUE TO 200.0 Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last.			
(b) Inferior Vena Caval Thrombophlebitis unknown			
DUE TO (c) Petechial Cell Sarcoma unknown			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(o)			
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 1b.)	
20c. TIME OF INJURY Month, Doy, Year Hour a. m. 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 28 Nov 1960, to 28 Nov 1960, that (I) (we) last saw the deceased alive on 28 Nov 1960, and that death occurred at 2 S M , from the causes and on the date stated above.			
22a. SIGNATURE L. Michael Glick		M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>	
22c. PHYSICIAN'S NAME (Type) L. MICHAEL GLICK, MD		22d. ADDRESS 126 N. SMALLWOOD ST.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 1/1/60	
23c. NAME OF CEMETERY OR CREMATORIAL St. Peter & Paul Cem		23d. LOCATION (City, town, or county) (State) Cumberland MD	
24. FUNERAL DIRECTOR'S SIGNATURE Louis Stein Inc. Cumb. MD		25a. REC'D BY REGISTRAR DATE DEC 1 '60	
		25b. REGISTRAR'S SIGNATURE Arthur S. Hayes	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4
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1

MARYLAND STATE DEPARTMENT OF HEALTH

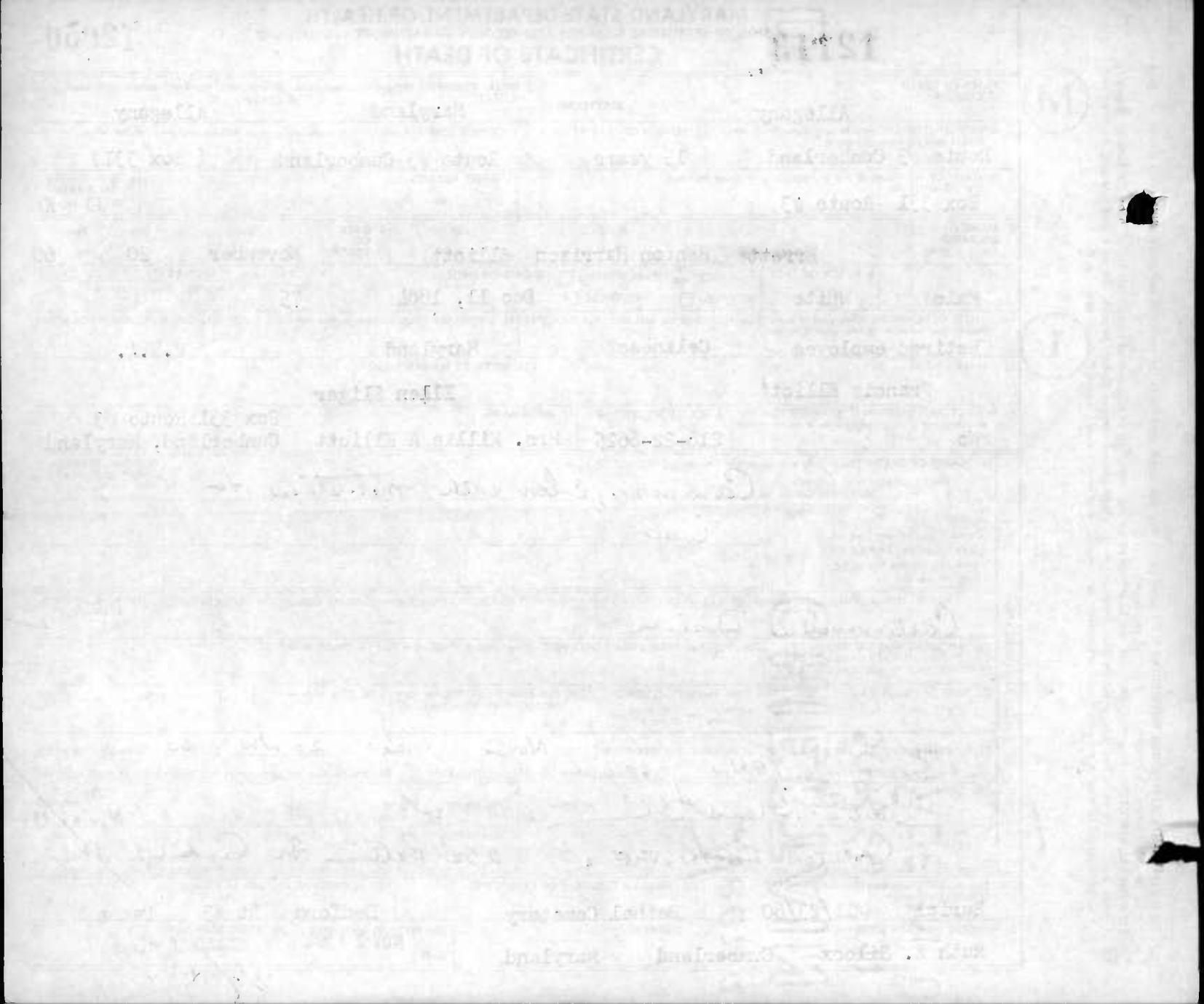
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

12113

CERTIFICATE OF DEATH

12050

1. PLACE OF DEATH a. COUNTY Allegany		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Route #3 Cumberland		c. LENGTH OF STAY IN 1b 15 years	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Box 331 Route #3		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) X Route #3 Cumberland (Box 331)	
3. NAME OF DECEASED (Type or print) Errett Benton Harrison Elliott		4. DATE OF DEATH Month November	
5. SEX Male		6. COLOR OR RACE White	
7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>		8. DATE OF BIRTH Dec 11, 1884	
9. AGE (In years last birthday) 75 yrs.		10. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired employee		10b. KIND OF BUSINESS OR INDUSTRY Celanese	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Francis Elliott		14. MOTHER'S MAIDEN NAME Ellen Sliger	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 216-22-6625	
17. INFORMANT Mrs. Millie A Elliott		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 153.8 DUE TO <i>Carcinoma, colon with metastasis to liver</i>	
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) (c)		INTERVAL BETWEEN ONSET AND DEATH ?	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Cardiovascular Disease			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from Nov 3 1960 to 20 Nov 1960 , that (I) (we) last saw the deceased alive on 19 Nov 1960 and that death occurred at M , from the causes and on the date stated above.			
22a. SIGNATURE Carlton Brunsford		22b. DATE SIGNED Nov 21 1960	
22c. PHYSICIAN'S NAME (Type) CARLTON BRUNSFORD		22d. ADDRESS 232 Bateman St Cumberland Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 11/23/60	
23c. NAME OF CEMETERY OR CREMATORIUM Bethel Cemetery		23d. LOCATION (City, town, or county) (State) Bedford Rt #3 Penna	
24. FUNERAL DIRECTOR'S SIGNATURE Ruth E. Silcox		25a. REC'D BY REGISTRAR DATE NOV 23 1960	
ADDRESS Cumberland Maryland		25b. REGISTRAR'S SIGNATURE Arthur S. Krause	



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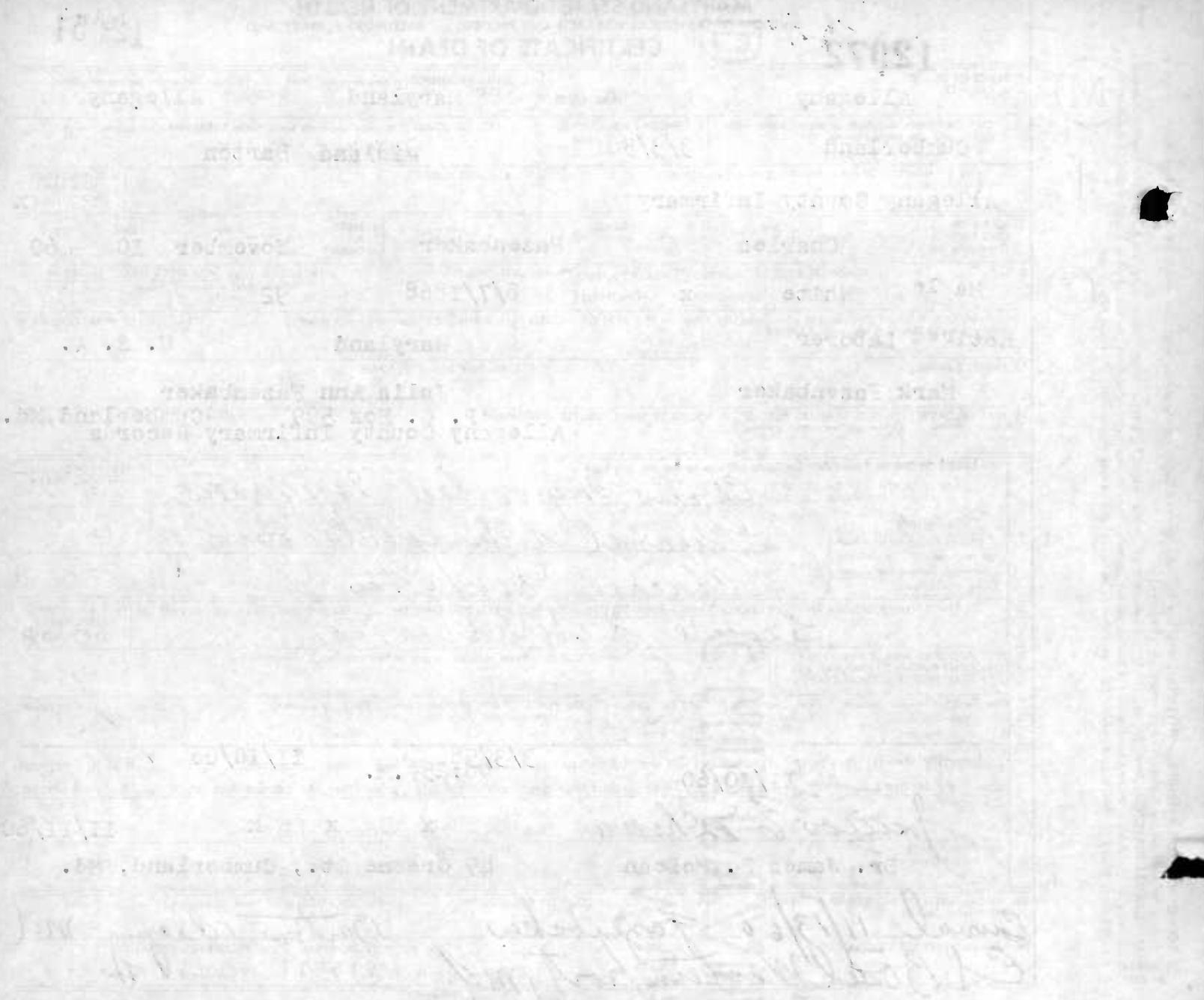
MARYLAND STATE DEPARTMENT OF HEALTH
 DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

12051

12072

CERTIFICATE OF DEATH

1. PLACE OF DEATH o. COUNTY Allegany		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cumberland		b. COUNTY Allegany	
c. LENGTH OF STAY IN 1b 3/3/58		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) # # # # # Barton	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Allegany County Infirmary		d. STREET ADDRESS	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print)	First Charles	Middle 	Last Fazenbaker
4. DATE OF DEATH	Month November	Day 10	Year 1960
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 8/7/1868
9. AGE (In years last birthday) 92	10. IF UNDER 1 YEAR Months 	11. IF UNDER 24 HRS. Days 	12. IF UNDER 24 HRS. Hours
10a. USUAL OCCUPATION (Give kind of work done during regular working life, even if retired) Retired Laborer	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country) Maryland	12. CITIZEN OF WHAT COUNTRY? U. S. A.
13. FATHER'S NAME Mark Fazenbaker		14. MOTHER'S MAIDEN NAME Julia Ann Fazenbaker	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO.	
17. INFORMANT P. O. Box 599 Allegany County Infirmary Records		Address: Cumberland, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]			
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Chronic myocardial degeneration</u> INTERVAL BETWEEN ONSET AND DEATH 422.1 DUE TO ?			
Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause lost. (b) <u>General arteriosclerosis</u> , ? (c) <u>Chronic nephritis</u> , ?			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <u>Senile Deterioration</u> 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>3/3/58</u> to <u>11/10/60</u> , that (I) (we) lost saw the deceased alive on <u>11/10/60</u> , and that death occurred at <u> </u> , M, from the causes and on the date stated above.			
22a. SIGNATURE <u>James E. McLean</u>		M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> 22b. DATE SIGNED <u>II/11/60</u>	
22c. PHYSICIAN'S NAME (Type) Dr. James E. McLean		22d. ADDRESS <u>49 Greene St., Cumberland, Md.</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 11/13/60	
23c. NAME OF CEMETERY OR CEMATORIAL Fazenbaker		23d. LOCATION (City, town, or county) Bartons, Allegany - Md (State)	
24. FUNERAL DIRECTOR'S SIGNATURE El. Boal Westernport, Md		25a. REC'D BY REGISTRAR DATE NOV 15 '60	
ADDRESS		25b. REGISTRAR'S SIGNATURE <u>Albert S. McLean</u>	



FOR STATE
HEALTH DEPT.

M

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PNA3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME
5M 2/57

18 MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

12052

Reg. Dist. No.

12110

1. PLACE OF DEATH a. COUNTY Allegany		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland		b. COUNTY Allegany	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Lonaconing		c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Lonaconing		d. STREET ADDRESS Washington Street	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Washington Street				e. IS RESIDENCE ON A FARM YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) CLARENCE		First M. Middle FAZENBAKER		4. DATE OF DEATH Nov 15		Month Nov Day 15 Year 1960	
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>		8. DATE OF BIRTH May 8th, 1895	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Garrett County		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Henry H. Fazenbaker		14. MOTHER'S MAIDEN NAME Elizabeth Broadwater		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes World War # 1		16. SOCIAL SECURITY NO.	
17. INFORMANT Mrs. Clarence Fazenbaker, Lonaconing (WIFE)		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 974X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		16. SOCIAL SECURITY NO.	
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)					
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input checked="" type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE WOMcLane		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED Nov 16 1960	
EXAMINER'S NAME (Type) WOMcLane MD		DEPUTY MEDICAL EXAMINER <input type="checkbox"/>					
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Nov, 19th. 1960		22c. NAME OF CEMETERY OR CREMATORIAL Oak Hill Cemetery, Lonaconing, MD.		22d. LOCATION (City, town, or county) (State)	
23. FUNERAL DIRECTOR'S SIGNATURE George Eichhorn		ADDRESS Lonaconing, MD.		24a. REC'D BY REGISTRAR NOV 21 '60		24b. REGISTRAR'S SIGNATURE George S. Thomas	

1514
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

STATE OF TEXAS
MEDICAL EXAMINER

DEATH CERTIFICATE

30 DECEMBER 1970

DEATH CERTIFICATE

DEATH CERTIFICATE

DEATH CERTIFICATE

DEATH CERTIFICATE

30 DECEMBER 1970

DEATH CERTIFICATE

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

12053

1. PLACE OF DEATH a. COUNTY Allegany		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) LaVale		c. LENGTH OF STAY IN 1b life	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 69 LaVale Blvd.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) ARTHUR E. GURLEY		First ARTHUR	Middle E.
4. DATE OF DEATH Nov. 7 1960		Month Nov.	Day 7
5. SEX Male		6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>
8. DATE OF BIRTH Jan. 24, 1914		9. AGE (In years last birthday) 46	10. IF UNDER 1 YEAR Months 0
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Bead clerk		10b. KIND OF BUSINESS OR INDUSTRY Tire Company	11. BIRTHPLACE (State or foreign country) Cumberland, Md.
13. FATHER'S NAME Harry J. Gurley		14. MOTHER'S MAIDEN NAME Leota R. Eyler	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 214 05 4148	17. INFORMANT Mrs. Mary Gurley, LaVale, Md.
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]		19. INTERVAL BETWEEN ONSET AND DEATH Minutes	
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 420 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. 1		Coronary occlusion	
DUE TO 1		Mild heart failure	
(b) DUE TO 1		9 days	
(c) 1			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) Congenital? Heart disease		20. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> 40 yrs?	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 1b.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> At work <input checked="" type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from 10-18-60 to 11-4 1960 , that (I) (we) last saw the deceased alive on 11-4 1960 , and that death occurred at 1A M., from the causes and on the date stated above.		22b. DATE SIGNED Nov 7-60	
22a. SIGNATURE Thomas F. Lusby		M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>	22b. ADDRESS 125 BEDFORD ST, CUMBERLAND, MD.
22c. PHYSICIAN'S NAME (Type) Thomas F. Lusby M.D.			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF Nov. 9, 1960	23c. NAME OF CEMETERY OR CREMATORIAL Greenmount Cemetery
24. FUNERAL DIRECTOR'S SIGNATURE Byron Kight		23d. LOCATION (City, town, or county) Cumberland, Md.	
ADDRESS Cumberland, Md.		25a. REC'D BY REGISTRAR NOV 14 '60	25b. REGISTRAR'S SIGNATURE Arthur E. Gurley

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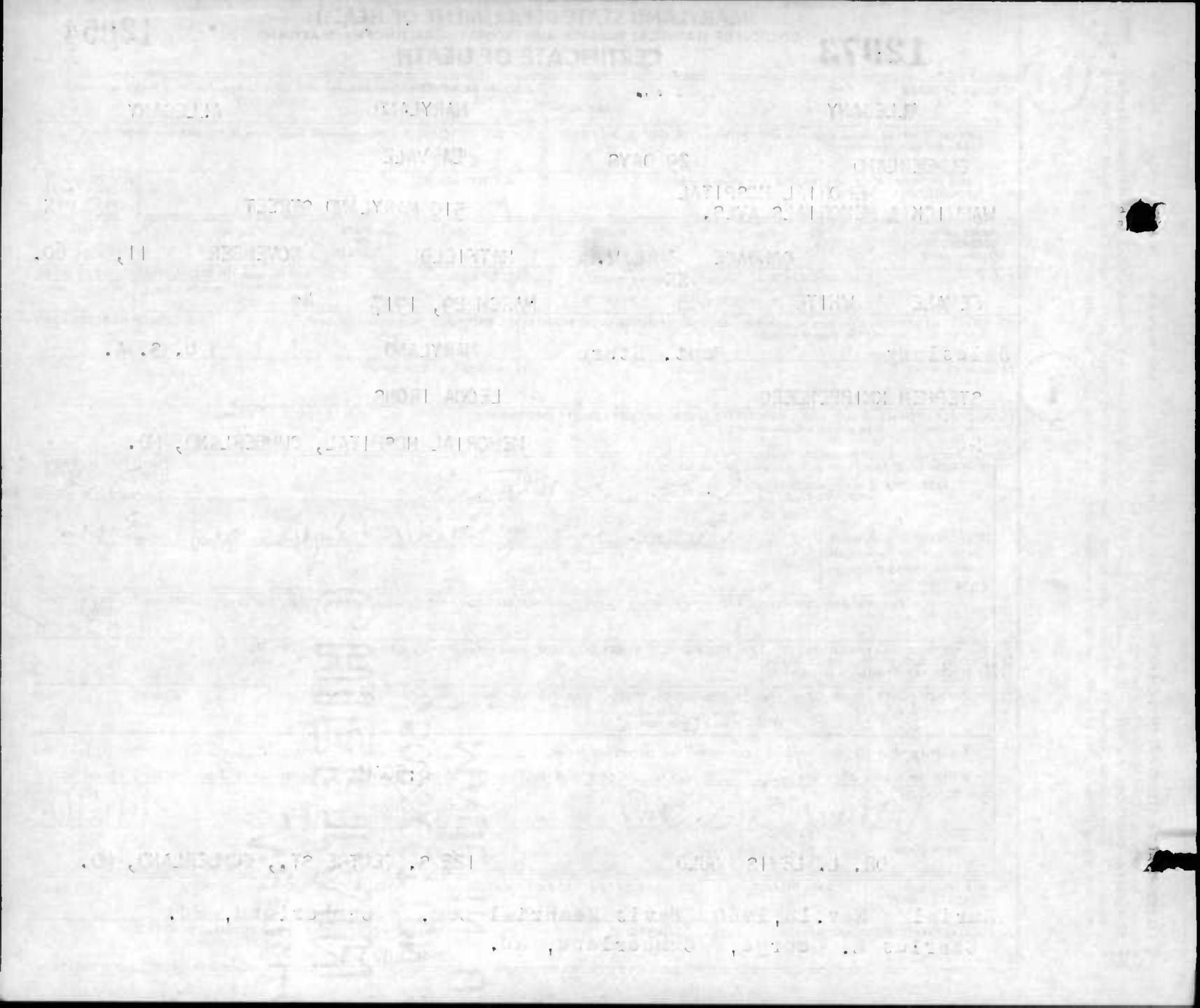
MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

12054

12073

CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY ALLEGANY		b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CUMBERLAND		c. LENGTH OF STAY IN 1b 29 DAYS		2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission) a. STATE MARYLAND		b. COUNTY ALLEGANY			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION MEMORIAL HOSPITAL WARWICK & MEMORIAL AVES.		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) LA VALE		d. STREET ADDRESS 510 MARYLAND STREET		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print) CANDACE WREATHA		First CANDACE	Middle WREATHA	Last HATFIELD	4. DATE OF DEATH NOVEMBER 11, 1960.	Month NOVEMBER	Day 11	Year 1960			
5. SEX FEMALE		6. COLOR OR RACE WHITE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH MARCH 29, 1917		9. AGE (In years last birthday) 43 yrs.	IF UNDER 1 YEAR Months 0	IF UNDER 24 HRS. Days 0	Hours 0	Min. 0
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Saleslady		10b. KIND OF BUSINESS OR INDUSTRY Dept. Store		11. BIRTHPLACE (State or foreign country) MARYLAND		12. CITIZEN OF WHAT COUNTRY? U. S. A.					
13. FATHER'S NAME STEPHEN KNIPPERBERG		14. MOTHER'S MAIDEN NAME LEONA IRONS		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO.		17. INFORMANT		Address MEMORIAL HOSPITAL, CUMBERLAND, MD.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]		INTERVAL BETWEEN ONSET AND DEATH 3 mos									
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 171X Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. (b) (c)		Cerebral Atherosclerosis Cerebrovascular Disease (Dysvascular) 3 yrs									
DUE TO											
DUE TO											
DUE TO											
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>									
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)									
20c. TIME OF INJURY Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)					
21. I certify that (I) (this hospital) attended the deceased from _____ 19 _____, to _____ 19 _____, that (I) (we) last saw the deceased alive on _____ 19 _____, and that death occurred at 6:50 AM from the causes and on the date stated above.											
22a. SIGNATURE 		M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED 11/12/60							
22c. PHYSICIAN'S NAME (Type) DR. L. LEWIS MOULD		22d. ADDRESS 122 S. CENTRE ST., CUMBERLAND, MD.									
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF Nov. 13, 1960		23c. NAME OF CEMETERY OR CREMATORIAL Davis Memorial Cem.		23d. LOCATION (City, town, or county) Cumberland, Md.		(State)			
24. FUNERAL DIRECTOR'S SIGNATURE Charles L. George,		ADDRESS Cumberland, Md.		25a. REC'D BY REGISTRAR NOV 14 '60		25b. REGISTRAR'S SIGNATURE 					



MARYLAND STATE DEPARTMENT OF HEALTH
 DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

12055

CERTIFICATE OF DEATH

12074		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)															
1. PLACE OF DEATH a. COUNTY ALLEGANY		b. STATE MARYLAND															
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CUMBERLAND		c. LENGTH OF STAY IN 1b 56 DAYS															
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION MEMORIAL HOSPITAL, MEMORIAL & WARWICK AVE		d. STREET ADDRESS 515 "B" STREET															
3. NAME OF DECEASED (Type or print)		First FREDERICK	Middle Lewis	Last HAWKINS	4. DATE OF DEATH NOVEMBER 15 1960	Month NOVEMBER	Day 15	Year 1960									
5. SEX MALE		6. COLOR OR RACE WHITE		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH JANUARY 20, 1893		9. AGE (In years last birthday) 67 yrs.		IF UNDER 1 YEAR Months 0		IF UNDER 24 HRS. Months 0					
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired Salesman		10b. KIND OF BUSINESS OR INDUSTRY Swift Meat Co.		11. BIRTHPLACE (State or foreign country) BEDFORD, PENN.		12. CITIZEN OF WHAT COUNTRY? U.S.A.											
13. FATHER'S NAME GEORGE HAWKINS		14. MOTHER'S MAIDEN NAME BLANCHE WELSH															
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No,		16. SOCIAL SECURITY NO. (If yes, give war or dates of service) 214-05-5886		17. INFORMANT MEMORIAL HOSPITAL - CUMBERLAND, MARYLAND		Address		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 331X Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. (b) DUE TO (c) DUE TO PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)				INTERVAL BETWEEN ONSET AND DEATH 30 days					
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 1b.) <i>Dept 20 Nov 15, 1960, to November 1960, that (I) (we) last saw the deceased alive on 11/15/1960, and that death occurred at 3:10 AM. The causes and on the date stated above.</i>										19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
20c. TIME OF INJURY Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) <i>Dept 20 Nov 15, 1960, to November 1960, that (I) (we) last saw the deceased alive on 11/15/1960, and that death occurred at 3:10 AM. The causes and on the date stated above.</i>		(County)		(State)							
21. I certify that (I) (this hospital) attended the deceased from and the deceased alive on 11/15/1960 , and that death occurred at 3:10 AM . The causes and on the date stated above.		22a. SIGNATURE <i>George M. Simons</i>										22b. DATE SIGNED 11/15/60					
22. PHYSICIAN'S NAME (Type) DR. GEORGE M. SIMONS		M.D. <input checked="" type="checkbox"/> ATTENDING PHYS.		MED. DIRECTOR <input type="checkbox"/>		STAFF PHYS. <input type="checkbox"/>		23a. BURIAL, CREMATION REMOVAL (Specify) Burial				23b. DATE THEREOF 11/17/60		23c. NAME OF CEMETERY OR CREMATORIUM Hillcrest Burial Park		23d. LOCATION (City, town, or county) <i>Dept 20 Nov 15, 1960, to November 1960, that (I) (we) last saw the deceased alive on 11/15/1960, and that death occurred at 3:10 AM. The causes and on the date stated above.</i>	
24. FUNERAL DIRECTOR'S SIGNATURE <i>H. Wayne George</i>		ADDRESS <i>Cumberland, Md.</i>		25a. REC'D BY REGISTRAR <i>NOV 21 '60</i>		25b. REGISTRAR'S SIGNATURE <i>Arthur S. Krause</i>		(State) <i>Cumberland, Md.</i>									

100%

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Y-159 Y-160 Y-161 Y-162 Y-163 Y-164 Y-165 Y-166 Y-167 Y-168

Y-169

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12075

CERTIFICATE OF DEATH

12056

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <i>Allegany</i> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE <i>Maryland</i> b. COUNTY <i>Allegany</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Cumberland Md</i>		c. LENGTH OF STAY IN 1b <i>1b</i>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>408 Walnut Street</i>		d. STREET ADDRESS <i>408 Walnut St. 1</i>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print)	First <i>Rose</i>	Middle <i>A</i>	Last <i>Higgins</i>
4. DATE OF DEATH	Month <i>Nov.</i>	Day <i>17</i>	Year <i>1960</i>
5. SEX <i>Female</i>	6. COLOR OR RACE <i>White</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> b. DATE OF BIRTH <i>Aug 10 1883</i>	WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>
8. AGE (In years last birthday) <i>77 yrs.</i>		9. IF UNDER 1 YEAR Months <i>0</i> Days <i>0</i>	10. IF UNDER 24 HRS. Hours <i>0</i> Min. <i>0</i>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Housewife</i>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <i>Glendale Md</i>		12. CITIZEN OF WHAT COUNTRY? <i>U. S. A.</i>	
13. FATHER'S NAME <i>Henry A Higgins</i>		14. MOTHER'S MAIDEN NAME <i>Elizabeth Hudson</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>No</i>		16. SOCIAL SECURITY NO. <i>None</i>	
17. INFORMANT <i>Miss Fannie Higgins, Cumb. Md</i>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Chromic Myocarditis</i>		INTERVAL BETWEEN ONSET AND DEATH <i>2 years</i>	
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) _____ DUE TO _____ (c) _____ DUE TO _____			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour o. m. <i>19</i> p. m. <i></i>		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg, etc.)		20f. (City or town) <i>Cumberland</i> (County) <i>Md</i> (State) <i>Md</i>	
21. I certify that I attended the deceased from <i>1958</i> to <i>11-17-1960</i> that I last saw the deceased alive on <i>September 1960</i> , and that death occurred at <i>8 A.M.</i> from the causes and on the date stated above.			
ACTUAL SIGNATURE <i>J. Johnson, Jr.</i>		ADDRESS (Street, city or town, state) <i>16 Greene St, Cumberland Md</i>	
PHYSICIAN'S NAME (Type)		DATE SIGNED <i>11-22-60</i>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		22b. DATE THEREOF <i>11/20/60</i>	
22c. NAME OF CEMETERY OR CREMATOR <i>St Patrick's Cem.</i>		22d. LOCATION (City, town, or county) <i>Cumberland Md</i> (State) <i>Md</i>	
23. FUNERAL DIRECTOR'S SIGNATURE <i>Louis Stein Inc. Cumb. Md.</i>		24a. REC'D BY REGISTRAR <i>NOV 22 '60</i> DATE	
		24b. REGISTRAR'S SIGNATURE <i>Arthur S. Evans</i>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician and completely filled in by the funeral director.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

60051

NAME OF DECEASED	AGE	SEX	CAUSE OF DEATH	DEATH DATE
WILLIAM H. BROWN	65	MALE	HEART DISEASE	1950-08-11
ADDRESS OF DECEASED				
1111 E. 36th Street, Baltimore, Maryland				
NAME AND ADDRESS OF PHYSICIAN				
Dr. J. E. BROWN, 1111 E. 36th Street, Baltimore, Maryland				
NAME AND ADDRESS OF FUNERAL DIRECTOR				
J. E. BROWN, 1111 E. 36th Street, Baltimore, Maryland				
NAME AND ADDRESS OF CEMETERY				
Baltimore Cemetery, 1111 E. 36th Street, Baltimore, Maryland				
TIME OF DEATH				
11:00 AM				
TIME OF FUNERAL				
12:00 PM				
TIME OF BURIAL				
12:00 PM				
NAME OF DECEASED				
WILLIAM H. BROWN				
ADDRESS OF DECEASED				
1111 E. 36th Street, Baltimore, Maryland				
NAME AND ADDRESS OF PHYSICIAN				
Dr. J. E. BROWN, 1111 E. 36th Street, Baltimore, Maryland				
NAME AND ADDRESS OF FUNERAL DIRECTOR				
J. E. BROWN, 1111 E. 36th Street, Baltimore, Maryland				
NAME AND ADDRESS OF CEMETERY				
Baltimore Cemetery, 1111 E. 36th Street, Baltimore, Maryland				
TIME OF DEATH				
11:00 AM				
TIME OF FUNERAL				
12:00 PM				
TIME OF BURIAL				
12:00 PM				
NAME OF DECEASED				
WILLIAM H. BROWN				
ADDRESS OF DECEASED				
1111 E. 36th Street, Baltimore, Maryland				
NAME AND ADDRESS OF PHYSICIAN				
Dr. J. E. BROWN, 1111 E. 36th Street, Baltimore, Maryland				
NAME AND ADDRESS OF FUNERAL DIRECTOR				
J. E. BROWN, 1111 E. 36th Street, Baltimore, Maryland				
NAME AND ADDRESS OF CEMETERY				
Baltimore Cemetery, 1111 E. 36th Street, Baltimore, Maryland				
TIME OF DEATH				
11:00 AM				
TIME OF FUNERAL				
12:00 PM				
TIME OF BURIAL				
12:00 PM				

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician and completely filled in by the funeral director.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

12057

1. PLACE OF DEATH a. COUNTY ALLEGANY		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CUMBERLAND		b. COUNTY ALLEGANY	
c. LENGTH OF STAY IN 1b 2 DAYS		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CUMBERLAND	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION MEMORIAL HOSPITAL MEMORIAL AVE.		d. STREET ADDRESS Pleasant View Road	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) THOMAS Patrick		First THOMAS	Middle Patrick
		Last HIGHLAND	4. DATE OF DEATH Month NOVEMBER Day 3 Year 1960
S. SEX MALE	6. COLOR OR RACE WHITE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH JULY 23 1877
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired Station Mgr. Pipe Line Co.		10b. KIND OF BUSINESS OR INDUSTRY Pipe Line Co.	
10c. BIRTHPLACE (State or foreign country) MARIETTA, OHIO		11. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME JOHN HIGHLAND		14. MOTHER'S MAIDEN NAME Briget Roland	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No,		16. SOCIAL SECURITY NO. 091-07-7700	
17. INFORMANT MEMORIAL HOSPITAL		Address CUMBERLAND, MD.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]			
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 44DX Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last.			
DUE TO <i>Chronic Hypertension</i>			
(b) DUE TO <i>Cardio Vasculos of Renal</i>			
(c) DUE TO <i>Decayed</i>			
INTERVAL BETWEEN ONSET AND DEATH <i>Jan 2 Dec 57</i>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. 19 p. m.		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 12-27-57 to 11-8-1960 that (I) last saw the deceased alive on 11-8-1960 and that death occurred at 4:45PM the causes and on the date stated above.			
22a. SIGNATURE <i>DR. W. F. Williams</i>		ATTENDING M.D. PHYS. <input type="checkbox"/>	MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>
22c. PHYSICIAN'S NAME (Type) DR. W. F. WILLIAMS		22d. ADDRESS <i>Cumberland, Md.</i>	
23a. BURIAL, CREMATION, REMOVAL (Specify) Bufail		23b. DATE THEREOF 11/12/60	
23c. NAME OF CEMETERY OR CREMATORIAL Newport Cemetery		23d. LOCATION (City, town, or county) (State) Newport, Ohio	
24. FUNERAL DIRECTOR'S SIGNATURE Charles L. George		ADDRESS Cumberland, Md.	
		25a. REC'D BY REGISTRAR NOV 14 '60	25b. REGISTRAR'S SIGNATURE <i>Charles L. George</i>

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4
may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

12058

12077

CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY Allegany		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cumberland		c. LENGTH OF STAY IN 1b 4/14/60	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Allegany County Infirmary		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print)	First Ida	Middle May	Last Hill
4. DATE OF DEATH November 8, 1960	Month November	Day 8	Year 1960
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 5/18/1879
9. AGE (In years last birthday) 81 yrs.	10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife	10b. KIND OF BUSINESS OR INDUSTRY Own home	11. BIRTHPLACE (State or foreign country) Pennsylvania
12. CITIZEN OF WHAT COUNTRY? U. S. A.	13. FATHER'S NAME William M. Wadsworth		
14. MOTHER'S MAIDEN NAME Mary Engle	15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No.		
16. SOCIAL SECURITY NO. None	17. INFORMANT P.O. Box 599, Allegany County Infirmary Records , Address Cumberland, Md.		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]			
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 722.0 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Chronic Myocardial Degeneration DUE TO Due to (c) Cerebral Arteriosclerosis Due to Chronic Pneumatoxanthritis DUE TO			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) Chronic Nephritis			
INTERVAL BETWEEN ONSET AND DEATH ?			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Hour a. m. p. m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from 4/14/60 , 19, to 11/8/60 , 19, that (I) (we) last saw the deceased alive on 11/7/60 , 19, at 6:15 A.M. , and that death occurred at M , from the causes and on the date stated above.			
22a. SIGNATURE James E. McLean		M.D. <input type="checkbox"/> ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input checked="" type="checkbox"/> STAFF PHYS. <input type="checkbox"/>	22b. DATE SIGNED 11/8/60
22c. PHYSICIAN'S NAME (Type) Dr. James E. McLean	22d. ADDRESS 49 Greene St., Cumberland, Md.		
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF 11/10/60	23c. NAME OF CEMETERY OR CREMATORY Greenmount Cemetery	23d. LOCATION (City, town, or county) (State) Cumberland, Maryland
24. FUNERAL DIRECTOR'S SIGNATURE Charles L. George		ADDRESS Cumberland, Md.	25a. REC'D BY REGISTRAR DATE NOV 14 '60
			25b. REGISTRAR'S SIGNATURE Arthur S. Kraus

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit Permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

12115 12059

1. PLACE OF DEATH a. COUNTY Allegany			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Flintstone			b. COUNTY Allegany		
c. LENGTH OF STAY IN 1b years			c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Flintstone		
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Residence, Flintstone, Maryland			d. STREET ADDRESS		
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print) BERGMAN			First MILVEE	Middle HINKLE	4. DATE OF DEATH Nov. 13 1960
5. SEX Male			6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH March 19, 1874
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired Farmer			10b. KIND OF BUSINESS OR INDUSTRY General Farming	11. BIRTHPLACE (State or foreign country) Murley's Branch, Md.	12. CITIZEN OF WHAT COUNTRY? USA
13. FATHER'S NAME Sumerfield Hinkle			14. MOTHER'S MAIDEN NAME Rhoda Wolford		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no			16. SOCIAL SECURITY NO.	17. INFORMANT	Address Mrs. Agnes B. Hinkle, Flintstone, Maryland
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 450.0 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) DUE TO			INTERVAL BETWEEN ONSET AND DEATH Generalized arteriosclerosis 3 years		
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (o)					
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		
20c. TIME OF INJURY Month, Day, Year Hour o. m. 19 p. m.			20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from 10-30 1960 to 11-13-1960 that (I) (we) last saw the deceased alive on 10-30-1960 and that death occurred at 9:00 AM , from the causes and on the date stated above.			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
22a. SIGNATURE J. Johnson, Jr.			M.D.	ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>	22b. DATE SIGNED 2-1-61
22c. PHYSICIAN'S NAME (Type) James T. Johnson, Jr. M.D.			22d. ADDRESS 16 Greene Street, Cumberland, Md.		
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF Nov. 16, 1960	23c. NAME OF CEMETERY OR CREMATORIAL Hillcrest Burial Park	23d. LOCATION (City, town, or county) Cumberland, Maryland	(State)
24. FUNERAL DIRECTOR'S SIGNATURE John J. Hafer, Cumberland, Maryland			ADDRESS	25a. REC'D BY REGISTRAR NOV 18 '60	25b. REGISTRAR'S SIGNATURE John J. Hafer

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4
 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove ~~burial~~ papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1 MARYLAND STATE DEPARTMENT OF HEALTH
 DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

12078 12060

CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY ALLEGANY		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CUMBERLAND		c. LENGTH OF STAY IN 1b 26 DAYS	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION MEMORIAL HOSPITAL MEMORIAL & WARWICK AVES.,		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print)	First FLORENCE	Middle L	Last JOHNSON
4. DATE OF DEATH	Month NOVEMBER	Day 23	Year 1960
5. SEX FEMALE	6. COLOR OR RACE WHITE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH FEBRUARY 22, 1892
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Seamstress	10b. KIND OF BUSINESS OR INDUSTRY Ready Wear Shop	11. BIRTHPLACE (State or foreign country) CUMBERLAND, MARYLAND	12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME WILLIAM E. JOHNSON	14. MOTHER'S MAIDEN NAME JOSEPHINE GRIFFLY		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Y, no, or unknown) 200	16. SOCIAL SECURITY NO. 319-14-6198	17. INFORMANT MEMORIAL HOSPITAL	Address CUMBERLAND, MD.
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 260 X Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. (b) DUE TO Arteriosclerotic Heart Disease (c) DUE TO Diabetes Mellitus		INTERVAL BETWEEN ONSET AND DEATH 3 HRS you you	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour a. m. p. m.	20d. INJURY OCCURRED While at work <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
19			
21. I certify that (I) (this hospital) attended the deceased from May 1955, to 11/12/3, 1960, that (I) (we) last saw the deceased alive on 11/12/3 1960, and that death occurred 7:45 AM from the causes and on the date stated above.			
22a. SIGNATURE George M. Simons	M.D. ATTENDING PHYS. <input checked="" type="checkbox"/>	MED. DIRECTOR <input type="checkbox"/>	STAFF PHYS. <input type="checkbox"/>
22b. PHYSICIAN'S NAME (Type) GEORGE M. SIMONS	22d. ADDRESS		
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF 11/26/60	23c. NAME OF CEMETERY OR CREMATORIAL Rose Hill Cem.	23d. LOCATION (City, town, or county) Cumberland 292 (State)
24. FUNERAL DIRECTOR'S SIGNATURE Louis Stein Inc. Cumb. Md.	ADDRESS	25a. REC'D BY REGISTRAR NOV 28 '60	25b. REGISTRAR'S SIGNATURE Arthur S. Trahan
VR A15 (4) 1SM 9/59		DATE	

REASON TO REINSTATE STATE OWNERSHIP
REASON TO REINSTATE

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

12061

CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY ALLEGANY			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CUMBERLAND, MD			b. COUNTY ALLEGANY		
c. LENGTH OF STAY IN 1b 8 DAYS			c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CUMBERLAND, MD.		
d. NAME OF HOSPITAL (If not in hospital, give street address) MEMORIAL HOSPITAL & WARWICK AVE.			d. STREET ADDRESS 699 GEPHART DRIVE		
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print)	First IVY	Middle GLADYS	Last JONES	4. DATE OF DEATH Month NOVEMBER	Day Year 22 1960
5. SEX FEMALE	6. COLOR OR RACE WHITE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	B. DATE OF BIRTH MAY 23, 1898	9. AGE (In years (on birthday) 62) yrs.	10. IF UNDER 1 YEAR Months 0
10a. USUAL OCCUPATION (Give kind of work done during most at working life, even if retired) Inspector		10b. KIND OF BUSINESS OR INDUSTRY Kelly-Tire Co.		11. BIRTHPLACE (State or foreign country) ENGLAND	
12. CITIZEN OF WHAT COUNTRY? U.S.A.					
13. FATHER'S NAME Albert TOOZE			14. MOTHER'S MAIDEN NAME ELEANOR ROGERS		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No.			16. SOCIAL SECURITY NO. 216-22-5662		
17. INFORMANT MEMORIAL HOSPITAL, CUMBERLAND, MARYLAND			Address		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Congestive Heart Failure			INTERVAL BETWEEN ONSET AND DEATH 8 hours		
158 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO Carcinoma, retroperitoneal, undifferentiated, (c) DUE TO site of origin undetermined.					
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)					
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		
20c. TIME OF INJURY Hour a. m. p. m. 19			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)			20f. (City or town) (County) (State)		
21. I certify that (I) (this hospital) attended the deceased from 11-14- 1960 , to 11-22- 1960 , that (I) (we) last saw the deceased alive on 11-22- 1960 , and that death occurred at 6:25 P.M. the causes and on the date stated above.					
22a. SIGNATURE WYAND F. DOERNER, JR.			22b. DATE SIGNED 11/25/60		
22c. PHYSICIAN'S NAME (Type) DR. WYAND F. DOERNER, JR.			22d. ADDRESS WASHINGTON ST., CUMBERLAND, MD.		
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 11/25/60		23c. NAME OF CEMETERY OR CREMATORIAL SS. Peter & Paul's	
23d. LOCATION (City, town, or county) Cumberland, Maryland			(State)		
24. FUNERAL DIRECTOR'S SIGNATURE Charles L. George			ADDRESS Cumberland, Md.		
25a. REC'D BY REGISTRAR DATE NOV 28 '60			25b. REGISTRAR'S SIGNATURE Arthur S. Jones		

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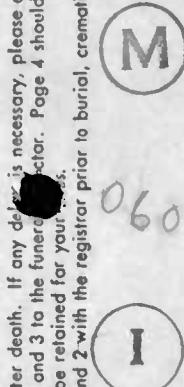
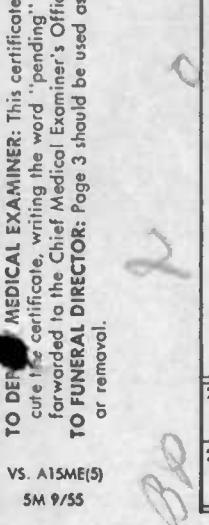
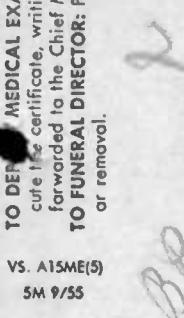
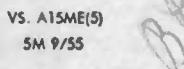
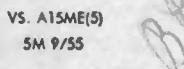
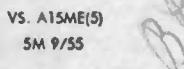
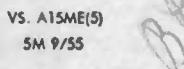
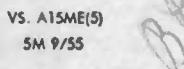
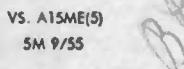
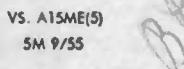
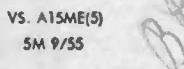
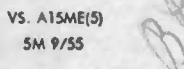
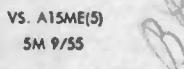
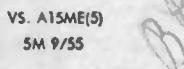
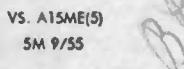
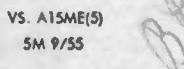
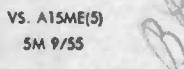
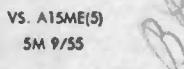
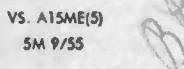
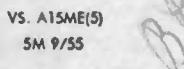
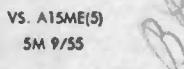
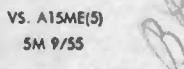
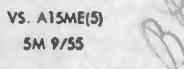
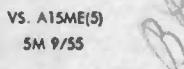
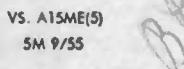
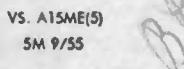
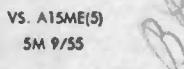
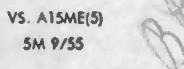
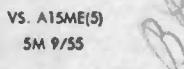
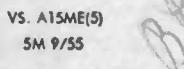
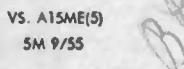
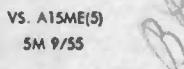
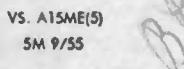
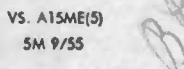
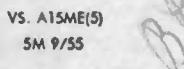
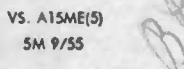
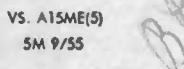
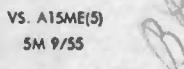
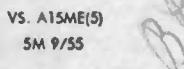
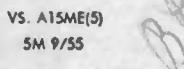
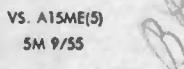
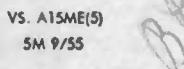
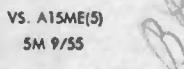
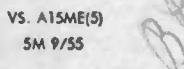
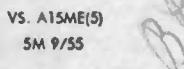
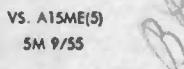
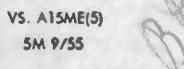
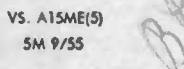
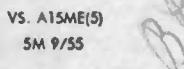
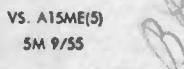
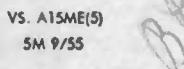
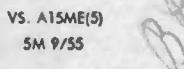
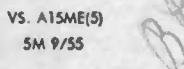
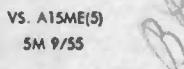
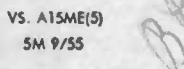
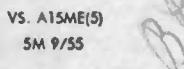
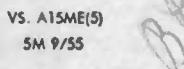
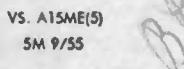
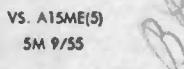
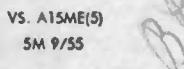
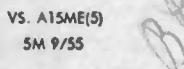
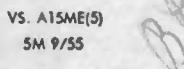
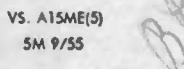
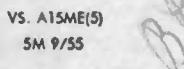
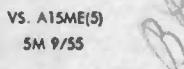
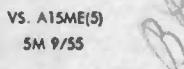
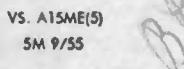
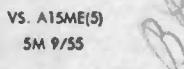
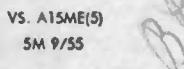
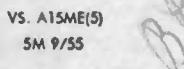
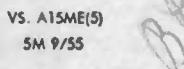
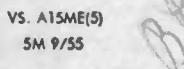
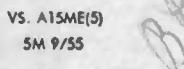
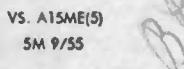
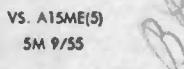
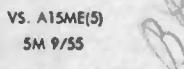
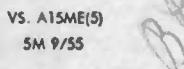
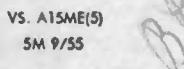
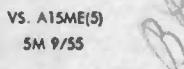
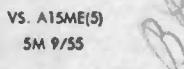
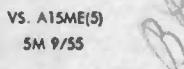
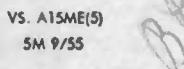
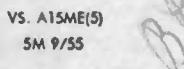
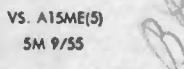
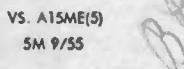
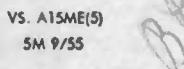
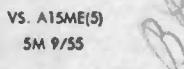
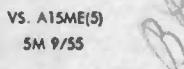
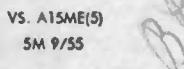
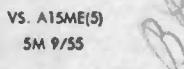
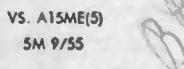
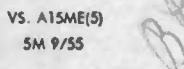
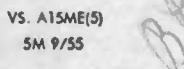
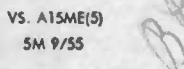
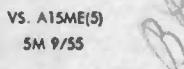
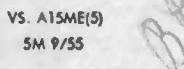
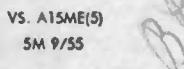
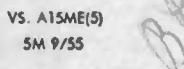
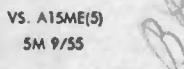
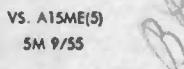
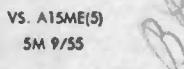
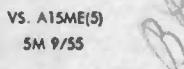
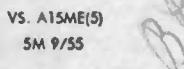
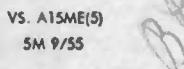
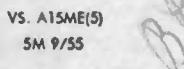
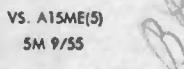
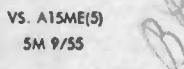
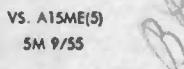
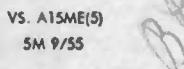
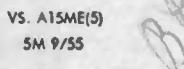
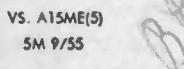
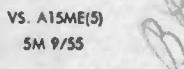
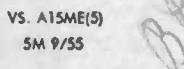
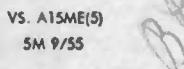
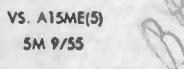
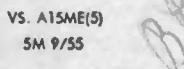
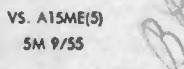
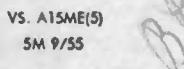
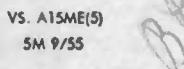
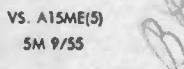
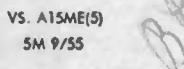
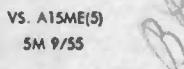
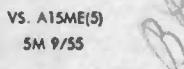
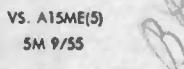
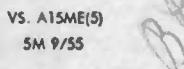
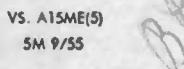
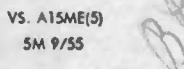
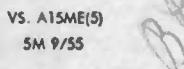
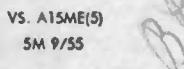
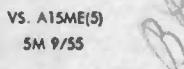
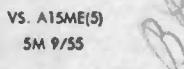
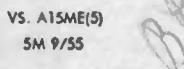
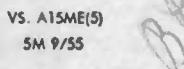
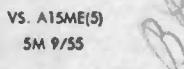
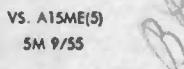
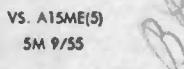
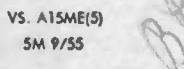
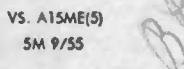
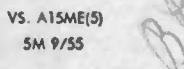
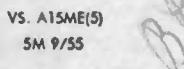
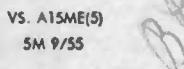
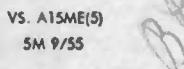
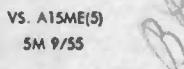
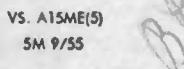
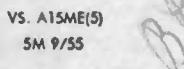
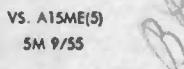
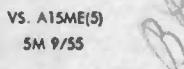
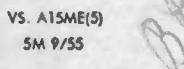
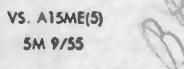
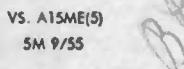
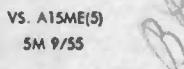
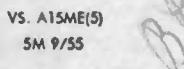
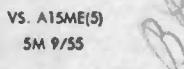
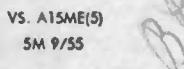
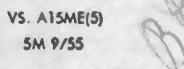
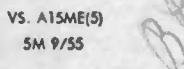
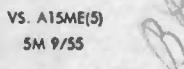
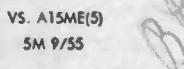
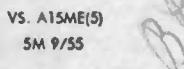
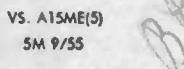
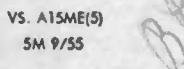
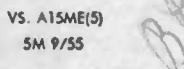
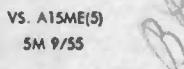
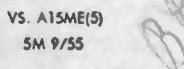
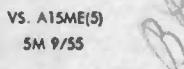
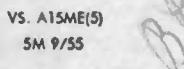
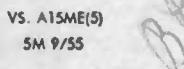
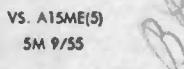
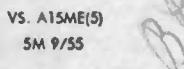
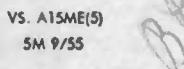
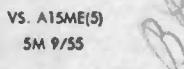
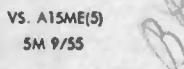
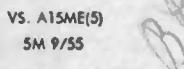
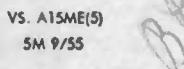
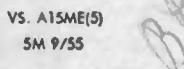
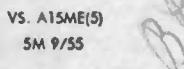
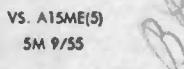
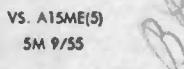
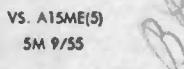
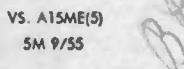
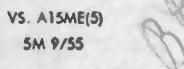
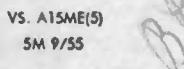
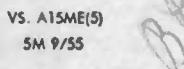
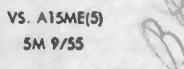
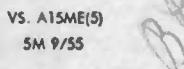
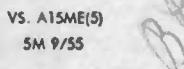
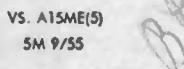
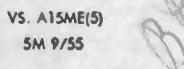
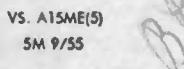
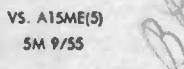
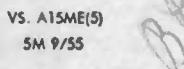
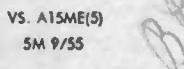
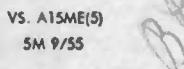
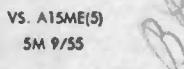
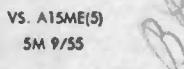
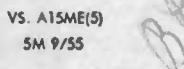
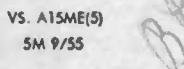
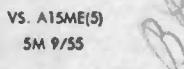
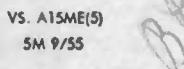
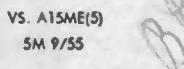
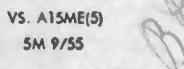
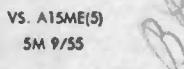
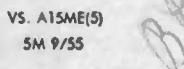
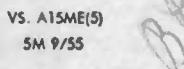
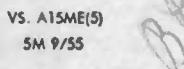
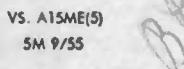
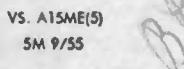
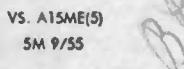
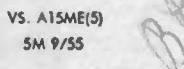
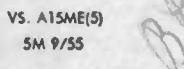
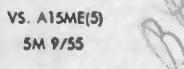
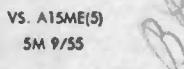
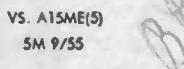
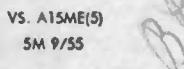
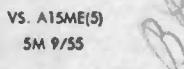
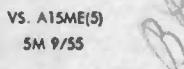
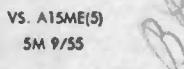
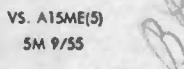
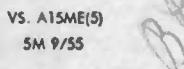
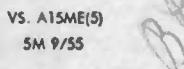
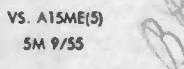
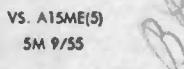
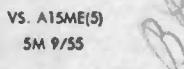
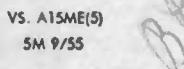
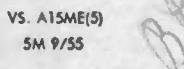
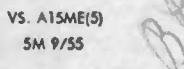
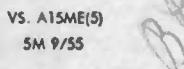
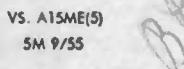
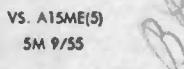
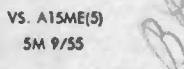
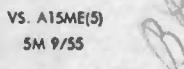
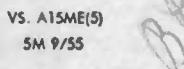
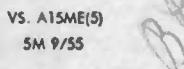
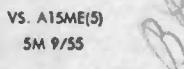
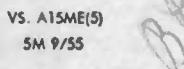
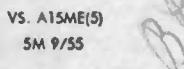
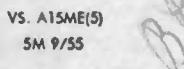
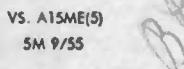
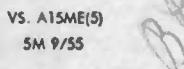
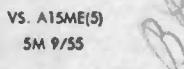
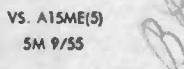
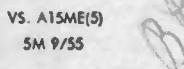
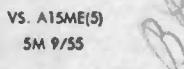
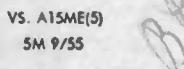
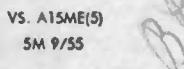
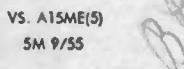
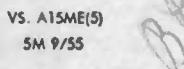
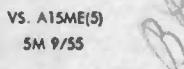
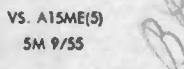
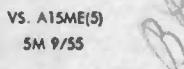
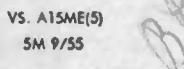
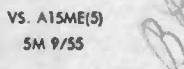
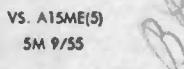
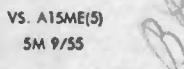
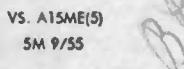
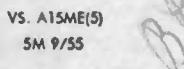
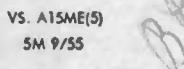
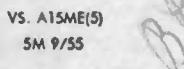
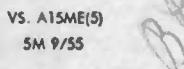
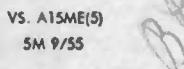
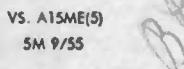
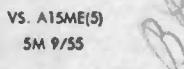
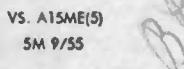
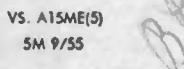
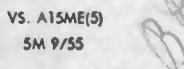
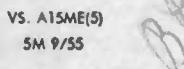
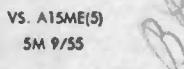
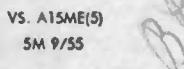
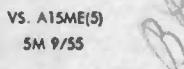
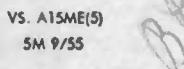
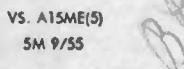
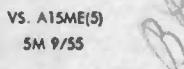
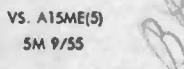
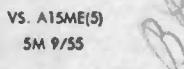
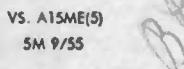
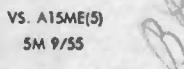
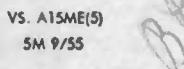
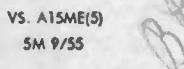
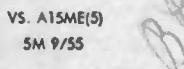
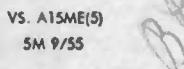
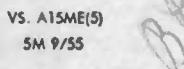
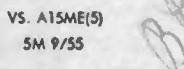
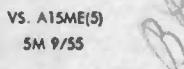
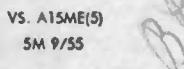
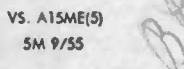
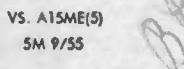
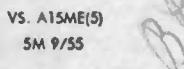
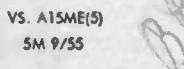
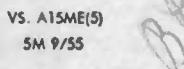
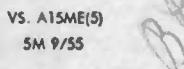
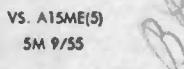
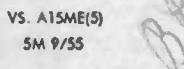
Y

Y

TO DEPARTMENTAL MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any death is necessary, please execute this certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with Form PM3. Page 5 may be retained for your records.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

VS. A15ME(5)
5M 9/55

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10. *Leucosia* *leucosia* (Linné) (Fig. 10)

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Digitized by srujanika@gmail.com

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be signed by the hospital or attending physician and completely filled in by the funeral director. Page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
1SM 9/59

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

12063

12116

Item 6 Form 1275 11-21-60 et

CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY Allegany		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Md	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Niket		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Niket	
c. LENGTH OF STAY IN 1b 34 Yrs		d. STREET ADDRESS State Road	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION State Road		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print)	First John	Middle Edmund	Last Kight
4. DATE OF DEATH	Month Nov.	Day 15	Year 1960
S. SEX Male	6. COLOR OR RACE Color	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH June 15, 1883
9. AGE (In years lost birthday) yrs. 77	10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer	10b. KIND OF BUSINESS OR INDUSTRY Paper Mill	11. BIRTHPLACE (State or foreign country) Maryland
12. CITIZEN OF WHAT COUNTRY? U.S.A.	13. FATHER'S NAME Charles A. Kight		
14. MOTHER'S MAIDEN NAME Eliza Gilbert	15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		
16. SOCIAL SECURITY NO. 216-05-6164	17. INFORMANT Mrs. John E. Kight-Niket, Md.	Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]			
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Myocardial Strain			
DUE TO (b) Arteriosclerotic Cardiovascular disease years			
Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause, if any. (c) Chronic bronchial asthma years			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (b)			
DUE TO Influenza			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		
20c. TIME OF INJURY Hour o. m. p. m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from Aug. 9 1956 to Nov. 15 1960 that (I) (we) last saw the deceased alive on Oct. 20 1960 , and that death occurred at 5AM , from the causes and on the date stated above.			
22a. SIGNATURE John E. Kight		22b. DATE SIGNED 11-15-60	
22c. PHYSICIAN'S NAME (Type) L.R. MILES, JR., M.D.	M.D. <input checked="" type="checkbox"/> ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>	22d. ADDRESS Sonacoming Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF 11/18/60	23c. NAME OF CEMETERY OR CREMATORIAL ADDRESS Phelps	23d. LOCATION (City, town, or county) (State) Westernport Md.
24. FUNERAL DIRECTOR'S SIGNATURE E.S. Bical	25a. REC'D BY REGISTRAR DATE NOV 17 '60	25b. REGISTRAR'S SIGNATURE Robert S. Turner	

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TO DEATH: MEDICAL EXAMINER: This certificate should be executed within 24 hours of death. If any delay is necessary, please execute the certificate, writing the word "pending", in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your records.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File page 1 and 2 with the registrar prior to burial, cremation, or removal.

13251

Reg. Dist. No.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
1208 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY Allegany		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE MARYLAND b. COUNTY Allegany	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cumberland		c. LENGTH OF STAY IN 1b d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Memorial Hospital	
d. STREET ADDRESS Oldtown		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
P.O. Box 15		4. DATE OF DEATH Month November Day 29 Year 1960	
3. NAME OF DECEASED (Type or print) Charles Emory Kimble	First Charles	Middle Emory	Last Kimble
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH Sept. 3, 1933
9. AGE (In years last birthday) 27 yrs.	10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer	11. KIND OF BUSINESS OR INDUSTRY George Const. Co.	12. BIRTHPLACE (State or foreign country) Landis, West Virginia
13. FATHER'S NAME Okey Kimble	14. MOTHER'S MAIDEN NAME Beaulah Alt		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) NO	16. SOCIAL SECURITY NO. 227-38-5755	17. INFORMANT s. Charles E. Kimble	Address P.O. BOX 15 Oldtown, Maryland
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]			
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Uremia DUE TO 884.9 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Mercury Poisoning DUE TO (c)			
Pending INTERVAL BETWEEN ONSET AND DEATH 3-4 Days			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.			
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Hour o. m. p. m.	Month, Day, Year 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)
21. I certify that I took charge of the remains described above, held on Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and find that death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input checked="" type="checkbox"/>			
ACTUAL SIGNATURE <i>Benedict Skitarelic</i>	DATE SIGNED M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		
EXAMINER'S NAME (Type) Benedict Skitarelic M.D.	Nov. 30, 1960		
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF December 2, 1960	22c. NAME OF CEMETERY OR CREMATORIAL Davis Memorial Cemetery	22d. LOCATION (City, town, or county) Allegany County, Maryland (State)
23. FUNERAL DIRECTOR'S SIGNATURE John J. Hafer, Cumberland, Maryland	ADDRESS	24a. REC'D BY REGISTRAR DEC 12 '60	24b. REGISTRAR'S SIGNATURE <i>John J. Hafer</i>

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OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4
may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

12064

1. PLACE OF DEATH a. COUNTY ALLEGANY		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CUMBERLAND		c. LENGTH OF STAY IN 1b 5 days	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION SACRED HEART		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CUMBERLAND	
3. NAME OF DECEASED (Type or print) LILLIAN MARIE LAWLER		4. DATE OF DEATH Month 11	Day Year 28 1960
S. SEX FEMALE	6. COLOR OR RACE WHITE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 3-25-92
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE		10b. KIND OF BUSINESS OR INDUSTRY Own Home	
10c. FATHER'S NAME Frederick Laing		11. BIRTHPLACE (State or foreign country) Maryland	
13. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		14. MOTHER'S MAIDEN NAME Catherine Long	
15. SOCIAL SECURITY NO. None		16. INFORMANT Albert Lawler-214 Fayette St. Cumb. Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral Vascular Accident, prob. thrombosis, right hemisphere DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. 443X		INTERVAL BETWEEN ONSET AND DEATH 4 days	
(b) Hypertensive and Arteriosclerotic Cardiovascular disease with cerebral arteriosclerosis and several old small strokes. DUE TO (c)		years	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from November 22 1960 to November 28, 1960 that (I) (we) last saw the deceased alive on November 28, 1960 , and that death occurred at 311B , from the causes and on the date stated above.			
22a. SIGNATURE <i>Edward F. Doerner, M.D.</i>		M.D. <input type="checkbox"/> ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>	22b. DATE SIGNED 11-30-60
22c. PHYSICIAN'S NAME (Type) W.F. DOERNER, M.D.		22d. ADDRESS ALGONQUIN 1111 BUILDING, CITY	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF Dec. 1, 1960	23c. NAME OF CEMETERY OR CREMATORIAL S.S. Peter & Paul Cem.
24. FUNERAL DIRECTOR'S SIGNATURE Charles L. George, Cumberland, Md.		25a. REC'D BY REGISTRAR DEC 2 '60	25b. REGISTRAR'S SIGNATURE Arthur S. Kraus

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

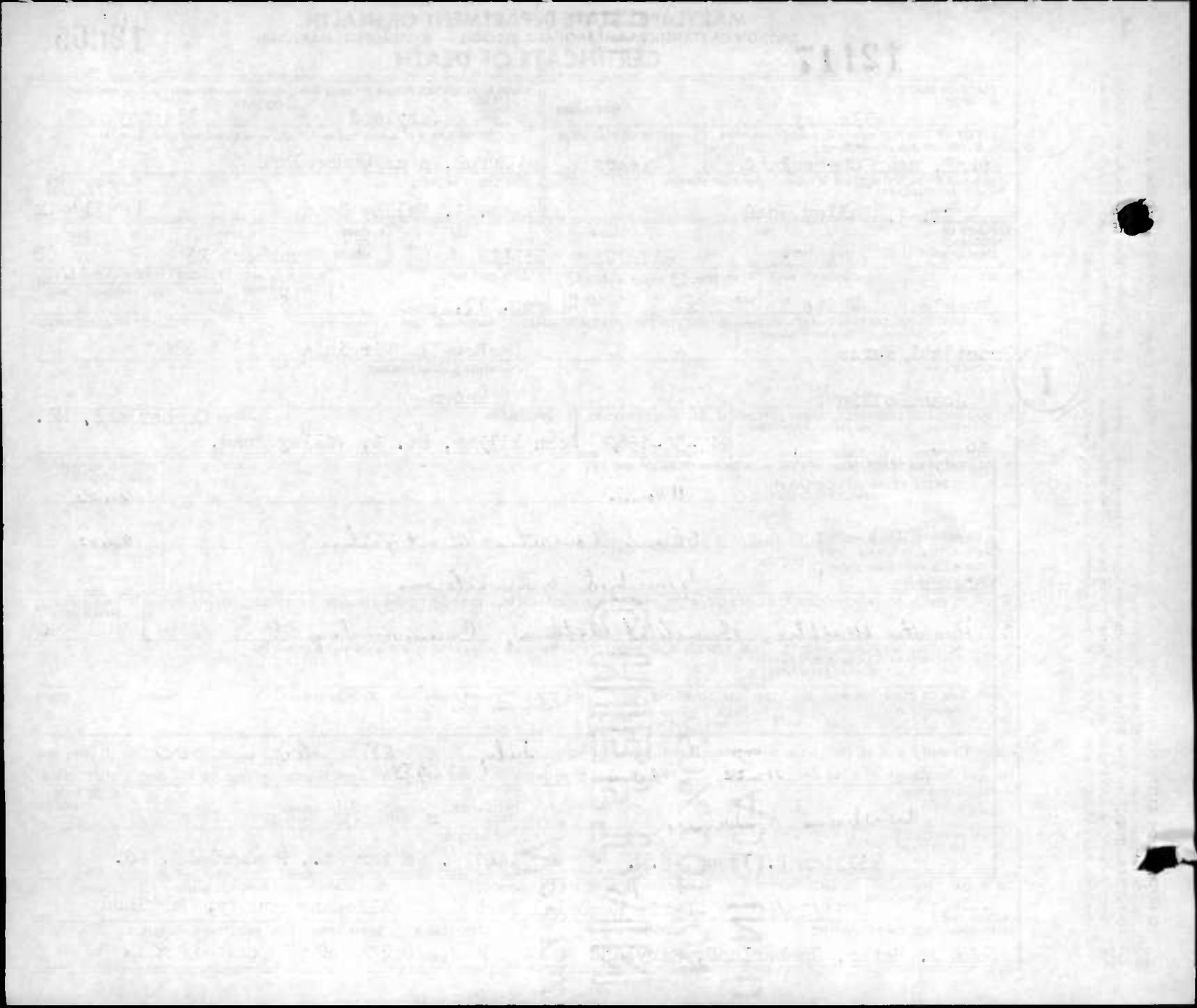
MARYLAND STATE DEPARTMENT OF HEALTH
 DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

12065

12117

CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY Allegany		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland		b. COUNTY Allegany			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural, near Cumberland		c. LENGTH OF STAY IN 1b years		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural, near Cumberland		d. STREET ADDRESS Rt. 1, Valley Road			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION RT. 1, Valley Road				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print) HARRIET		First BEATRICE	Middle LILLER	Last 	4. DATE OF DEATH Month November	Month 25	Doy 19	Year 60	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>		8. DATE OF BIRTH Feb. 11, 1895	9. AGE (In years last birthday) 65 yrs.	IF UNDER 1 YEAR Months 	IF UNDER 24 HRS. Days 	Hours 	Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Practical Nurse		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) McDowell, Virginia		12. CITIZEN OF WHAT COUNTRY? USA			
13. FATHER'S NAME John Botkin				14. MOTHER'S MAIDEN NAME Unknown					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. (If yes, give war or dates of service) 217-30-1562		17. INFORMANT John liller, Rt. 1, Valley Road,		Address Cumberland, Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 450-9		DUE TO ulremia		INTERVAL BETWEEN ONSET AND DEATH 4 weeks					
Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause lost. (b)		DUE TO Chronic Congestive Heart Failure		INTERVAL BETWEEN ONSET AND DEATH 6 mos.					
C		(c) Generalized arteriosclerosis							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a) Diabetes Mellitus, Bronchial asthma, Cerebrovascular?						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) 11-22 1960							
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) 441		(County) Center St.,	(State) Cumberland, Md.
21. I certify that (I) (this hospital) attended the deceased from July 1958 to Nov 1960 that (I) (we) last saw the deceased alive on 11-22 1960 , and that death occurred at 9:50 M, from the causes and on the date stated above.									
22a. SIGNATURE William P. James		M.D.		ATTENDING PHYS. <input checked="" type="checkbox"/>	MED. DIRECTOR <input type="checkbox"/>	STAFF PHYS. <input type="checkbox"/>	22b. DATE SIGNED 		
22c. PHYSICIAN'S NAME (Type) William P. James, M.D.		22d. ADDRESS 441 Center St., Cumberland, Md.							
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 11/28/60		23c. NAME OF CEMETERY OR CREMATORIAL Davis Memorial Park		23d. LOCATION (City, town, or county) Allegany County, Maryland		(State)	
24. FUNERAL DIRECTOR'S SIGNATURE John J. Hafer, Cumberland, Maryland		ADDRESS		25a. REC'D BY REGISTRAR DATE DEC 1 '60		25b. REGISTRAR'S SIGNATURE Arthur S. Kraus			



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician and completely filled in by the funeral director.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

12066

1. PLACE OF DEATH a. COUNTY Allegany		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Allegany	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cumberland		c. LENGTH OF STAY IN 1b 5/26/58	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Allegany County Infirmary		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 02 Cumberland	
3. NAME OF DECEASED (Type or print) Edward		4. DATE OF DEATH Month November Day 19 , Year 1960	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 3/2/1880
9. AGE (In years last birthday) 80 yrs.		10. IF UNDER 1 YEAR Months <input type="checkbox"/> Days <input type="checkbox"/> Hours <input type="checkbox"/> Min. <input type="checkbox"/>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired: R. R. Machinist (R. Road)		10b. KIND OF BUSINESS OR INDUSTRY Cumberland, Maryland	
11. BIRTHPLACE (State or foreign country) Cumberland, Maryland		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME Henry T. Logsdon		14. MOTHER'S MAIDEN NAME Sarah Smysing	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) 70		16. SOCIAL SECURITY NO. None	
17. INFORMANT P.O. Box 599, Allegany County Infirmary Records		Address Cumberland, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]			
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 422.1 DUE TO Hepatocirrhosis, chronic, severe Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. (b) extasis - delusion, severe (c) atalectasis			
INTERVAL BETWEEN ONSET AND DEATH			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 1b.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 5/26/58 19 to 11/19/60 , 19, that (I) (we) last saw the deceased alive on 11/19/60 19, and that death occurred at 6:30 P.M. M, from the causes and on the date stated above.			
22a. SIGNATURE L. B. Mathews		22b. DATE 11/21/60	
22c. PHYSICIAN'S NAME (Type) Dr. Lee B. Mathews		22d. ADDRESS 49 Greene St., Cumberland, Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 11/23/60	
23c. NAME OF CEMETERY OR CREMATORIAL SS Petey Paul Cem.		23d. LOCATION (City, town, or county) Cumberland MD	
24. FUNERAL DIRECTOR'S SIGNATURE Lewis Stein Inc. Cumb. Md.		25a. REC'D BY REGISTRAR DATE NOV 22 '60	
		25b. REGISTRAR'S SIGNATURE Charles S. Krause	

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4
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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
12084 CERTIFICATE OF DEATH

Reg. Dist. No. 12067

1. PLACE OF DEATH a. COUNTY Allegany			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cumberland			c. LENGTH OF STAY IN 1b c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cumberland		
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 1040 Bedford St.,			d. STREET ADDRESS 1040 Bedford St.,		
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print)		First Fredericka	Middle Mary	Last Loibel	4. DATE OF DEATH Month Nov. Day 5, Year 1960
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Dec. 15, 1893		9. AGE (In years last birthday) 66 yrs. IF UNDER 1 YEAR Months Days
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Own home	11. BIRTHPLACE (State or foreign country) Midland, Maryland		12. CITIZEN OF WHAT COUNTRY? U. S. A.
13. FATHER'S NAME Joseph Cutter			14. MOTHER'S MAIDEN NAME Jean Bobe		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes or no or unknown) No		16. SOCIAL SECURITY NO. None	17. INFORMANT Mr. John J. Loibel	Address Cumberland, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 420.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. (b) DUE TO (c)			INTERVAL BETWEEN ONSET AND DEATH		
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) Pulmonary Emphysema & Fibrosis			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.		20d. INJURY OCCURRED White <input type="checkbox"/> Not white <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 9/15 , 19 57 , to 11/5 , 19 60 , that I last saw the deceased alive on 9/21 , 19 60 , and that death occurred at 6:00 P.M. from the causes and on the date stated above. ACTUAL SIGNATURE <i>Leo H. Ley Jr.</i> M.D. 441 N. Centre St., ADDRESS (Street, city or town, state) 11/7/60					
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 11/8/60	22c. NAME OF CEMETERY OR CREMATORIAL SS. Peter & Paul's	22d. LOCATION (City, town, or county) Cumberland, Maryland (State)	
23. FUNERAL DIRECTOR'S SIGNATURE Charles L. George			ADDRESS Cumberland, Md.	24a. REC'D BY REGISTRAR DATE NOV 9 '60	24b. REGISTRAR'S SIGNATURE <i>John S. Kraus</i>

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 10/57

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Item 1 FilmG277 12-21-60 et

12105

CERTIFICATE OF DEATH

Reg. Dist. No.

12068

1. PLACE OF DEATH a. COUNTY ALLEGANY		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MD	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) FROSTBURG-MD		c. LENGTH OF STAY IN 1b 2 WKS	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Miners Hospital		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) RURAL LONACONING MD	
d. STREET ADDRESS 11 X - 2		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print)	First Lula	Middle M	Last McKenzie
4. DATE OF DEATH 11 20 1960	Month	Day	Year
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH JUNE 14 1891
		WIDOWED <input type="checkbox"/>	DIVORCED <input type="checkbox"/>
9. AGE (In years lost birthday) yrs. 69	10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE	11. KIND OF BUSINESS OR INDUSTRY OWN Home	12. BIRTHPLACE (State or foreign country) GARRETT Co MD
13. FATHER'S NAME JOSEPH ROBESON	14. MOTHER'S MAIDEN NAME RHODA GARLITZ	15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) NO	
16. SOCIAL SECURITY NO. 219-34-6526	17. INFORMANT Raymond McKenzie, MD Lonaconing MD	18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 420 DUE TO Pulmonary embolism INTERVAL BETWEEN ONSET AND DEATH 2 hrs.	
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) (c)	DUE TO Coronary occlusion possible DUE TO cholecystectomy	24 hrs. 4 days-	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from Nov 11, 1960 to Nov 20, 1960 , that I last saw the deceased alive on Nov 20, 1960 , and that death occurred at 3:30 P.M. from the causes and on the date stated above.			
ACTUAL SIGNATURE John B. Davis, M.D.	ADDRESS (Street, city or town, state) 2 Broadway, Frostburg, MD		
PHYSICIAN'S NAME (Type) John B. Davis, MD.	DATE SIGNED 11/21/60		
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL	22b. DATE THEREOF 11/23/60	22c. NAME OF CEMETERY OR CREMATORIAL St. ANNS	22d. LOCATION (City, town, or county) (State) ALVITON, GARRETT Co MD
23. FUNERAL DIRECTOR'S SIGNATURE Don Newman, Grantsville, Md	ADDRESS	24a. REC'D BY REGISTRAR NOV 29 '60	24b. REGISTRAR'S SIGNATURE Col. S. T. Tamm

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
12085 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

12069

Reg. Dist. No.

TO DEPT. MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute this certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your information.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File Pages 1 and 2 with the registrar prior to burial, cremation, or removal.

1. PLACE OF DEATH a. COUNTY Allegany		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE Maryland	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cumberland		c. LENGTH OF STAY IN 1b years	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 158½ Bedford Street		d. STREET ADDRESS 158½ Bedford Street	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print)	First MYRTLE	Middle JENNIE	Last MERRILL
4. DATE OF DEATH November 25 1960	Month 25	Day 19	Year 60
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Sept. 17, 1886
9. AGE (in years last birthday) 74 yrs.	10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife	10b. KIND OF BUSINESS OR INDUSTRY Own Home	11. BIRTHPLACE (State or foreign country) Mann's Choice, Pennsylvania
12. CITIZEN OF WHAT COUNTRY? USA			
13. FATHER'S NAME David Keifer		14. MOTHER'S MAIDEN NAME Dilla Malissa Barthalow	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no	16. SOCIAL SECURITY NO. none	17. INFORMANT Mrs. Ray Frankenberry, Cresaptown, Maryland	Address
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]			
PART I. DEATH WAS CAUSED BY, IMMEDIATE CAUSE (a) <u>Coronary Occlusion</u> DUE TO <u>420.1</u>			
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Coronary Sclerosis</u> DUE TO <u>420.1</u> (c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m.		20d. INJURY OCCURRED White at work <input type="checkbox"/> Not white at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .			
ACTUAL SIGNATURE EXAMINER'S NAME (Type)	Benedict Skitarelic, M.D.		
M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			DATE SIGNED November 25, 1960
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF Nov. 27, 1960	22c. NAME OF CEMETERY OR CREMATORIUM Mt. Savage Meth. Cemetery	22d. LOCATION (City, town, or county) Mt. Savage, Maryland
23. FUNERAL DIRECTOR'S SIGNATURE John J. Hafer, Cumberland, Maryland	ADDRESS	24a. REC'D BY REGISTRAR DEC 1 '60	24b. REGISTRAR'S SIGNATURE Arthur S. Tinsley

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4
 may be retained by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director,
 page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with
 the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
 DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

12070

1. PLACE OF DEATH a. COUNTY ALLEGANY		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) b. STATE MARYLAND							
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CUMBERLAND, MD.		c. LENGTH OF STAY IN 1b 114 DAYS							
d. NAME OF HOSPITAL (If not in hospital, give street address) MEMORIAL HOSPITAL MEMORIAL & WARWICK AVE.		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CUMBERLAND, MARYLAND							
3. NAME OF DECEASED (Type or print) JOHN		First H.	Middle MILLER	Last MILLER	4. DATE OF DEATH NOVEMBER 7, 1889	Month NOVEMBER	Day 26	Year 1960	
5. SEX MALE		6. COLOR OR RACE WHITE		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH NOVEMBER 7, 1889		9. AGE (In years last birthday) 71 yrs.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired Yard Foreman		10b. KIND OF BUSINESS OR INDUSTRY Railroad		11. BIRTHPLACE (State or foreign country) MANN'S CHOICE, PENNA.		12. CITIZEN OF WHAT COUNTRY? U.S.A.			
13. FATHER'S NAME EMMANUEL MILLER		14. MOTHER'S MAIDEN NAME ARMANDA FLEEGLE							
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 705-07-9529		17. INFORMANT MEMORIAL HOSPITAL, CUMBERLAND, MD.		Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>4/22.</i> Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last.		DUE TO (b) <i>Chronic myocarditis</i>		Armandia		INTERVAL BETWEEN ONSET AND DEATH <i>4 yrs</i>			
DUE TO (c) <i>Arteriosclerosis</i>									
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from <i>1927 to Nov. 26 1960</i> , that (I) (we) last saw the deceased alive on <i>Nov. 26 1960</i> , and that death occurred at <i>8:15 P.M.</i> the causes and on the date stated above.									
22a. SIGNATURE <i>Clay E. Durrett</i>		M.D. ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>				22b. DATE SIGNED <i>1/28/60</i>			
22c. PHYSICIAN'S NAME (Type) DR. CLAY E. DURRETT		22d. ADDRESS <i>2340 Valley Cumberland, Md. 1/28/60</i>							
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF II-30-60		23c. NAME OF CEMETERY OR CREMATORIAL Rose Hill Cem.		23d. LOCATION (City, town, or county) (State) Cumberland, Md.			
24. FUNERAL DIRECTOR'S SIGNATURE James F. Scarpelli		ADDRESS Cumberland, Md.		25a. REC'D BY REGISTRAR NOV 29 '60		25b. REGISTRAR'S SIGNATURE <i>Arthur S. Kraus</i>			

1
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
 DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

12071

12087

CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY ALLEGANY MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND b. COUNTY ALLEGANY									
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CUMBERLAND		c. LENGTH OF STAY IN 1b 4 DAYS									
d. NAME OF HOSPITAL (If died in hospital, give street address) OR INSTITUTION MEMORIAL HOSPITAL MEMORIAL & WARWICK AVES.,		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CUMBERLAND									
3. NAME OF DECEASED (Type or print) KATHERINE Lupton		4. DATE OF DEATH Month NOVEMBER 2 Year 1960									
5. SEX FEMALE WHITE		6. COLOR OR RACE 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		8. DATE OF BIRTH JUNE 14, 1914		9. AGE (In years last birthday) 46 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.		11. IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Hospital Employee		10b. KIND OF BUSINESS OR INDUSTRY Memorial Hospital		11. BIRTHPLACE (State or foreign country) CUMBERLAND, MD.		12. CITIZEN OF WHAT COUNTRY? U.S.A.					
13. FATHER'S NAME FRED SMITH		14. MOTHER'S MAIDEN NAME CATHERINE SHAFFER		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO.		17. INFORMANT		Address MEMORIAL HOSPITAL, CUMBERLAND, MD.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]		PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 420.1 Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. (b) DUE TO		Multiple emboli		INTERVAL BETWEEN ONSET AND DEATH immediate					
		DUE TO Mural thrombi (c)		Auricular fibrillation, acute post-mitral commissurotomy							
PART II. OTHER SIGNIFICANT CONDITIONS Multi-valvular rheumatic disease; hypertension								19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		20c. TIME OF INJURY Month, Day, Year Hour o. m. 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 10/25 1960 to 11/2 1960, that (I) (we) last saw the deceased alive on 11/2 1960 and that death occurred at 1:15 PM. The causes and on the date stated above.		22a. SIGNATURE Samuel M. Jacobson, M. D.		M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED 11/3/60					
22c. PHYSICIAN'S NAME (Type) Samuel M. Jacobson, M. D.		22d. ADDRESS 50 Pershing St., Cumberland, Md.									
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF Nov. 5, 1960		23c. NAME OF CEMETERY OR CREMATORIUM Rose Hill Cemetery		23d. LOCATION (City, town, or county) Cumberland, Maryland		(State)			
24. FUNERAL DIRECTOR'S SIGNATURE John J. Hafer, Cumberland, Maryland		ADDRESS		25a. REC'D BY REGISTRAR DATE NOV 7 '60		25b. REGISTRAR'S SIGNATURE Arthur S. Kraus					

YACHTS

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12106 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

12072

Reg. Dist. No.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your records.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File Pages 1 and 2 with the registrar prior to burial, cremation, or removal.

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1. PLACE OF DEATH a. COUNTY Allegany		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE Maryland b. COUNTY Allegany	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Frostburg		c. LENGTH OF STAY IN 1b Lifetime		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Frostburg	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 73 Bowery Street		d. STREET ADDRESS 73 Bowery Street		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) WILLIAM		First ALBERT	Middle PATTON	4. DATE OF DEATH Month 11 Day 27 Year 1960	
5. SEX M	6. COLOR OR RACE W	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH 5-11-1911	9. AGE (In years last birthday) 49 yrs.	IF UNDER 1 YEAR Months 0 Days 0 Hours 0 Min. 0 IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Tool Dye Assembly		10b. KIND OF BUSINESS OR INDUSTRY Cleveland, Ohio		11. BIRTHPLACE (State or foreign country) Eckhart	
13. FATHER'S NAME Albert Patton		14. MOTHER'S MAIDEN NAME Marie Brunner		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 217-10-5267		17. INFORMANT Address Mrs. Olive Patton, 73 Bowery, Frostburg, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]		INTERVAL BETWEEN ONSET AND DEATH			
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) a CORONARY OCCLUSION, RIGHT 420.1 DUE TO Conditions, If any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Coronary sclerosis with thrombosis DUE TO (c)		2-4 Hrs.			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Hour a. m. p. m.		Month, Day, Year 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and find that death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/>					
ACTUAL SIGNATURE <i>W.O. McLane</i>		DATE SIGNED M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) W.O. McLane, Jr.		M.D. ass't DEPUTY MEDICAL EXAMINER <input type="checkbox"/> November 27, 1960			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF II-30-1960	22c. NAME OF CEMETERY OR CREMATORIAL St. Michaels Cemetery	22d. LOCATION (City, town, or county) Frostburg (State) Md.	
23. FUNERAL DIRECTOR'S SIGNATURE <i>Reuben H. Montesent</i>		ADDRESS Hafer Funeral Home 23 E. Main, Frostburg, Md.		24a. REC'D BY REGISTRAR DEC 1 '60	24b. REGISTRAR'S SIGNATURE John S. Trahan

1 MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No.

12073

12088

TO DEFENDANT: MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending", in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your records.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File Pages 1 and 2 with the registrar prior to burial, cremation, or removal.

I. PLACE OF DEATH
a. COUNTY
ALLEGANY

MARYLAND

b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)

CUMBERLAND

c. LENGTH OF STAY IN 1b

6 HOURS

d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)

SACRED HEART HOSPITAL

2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission)
a. STATE
WEST VIRGINIA

b. COUNTY
MINERAL

c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)

RIDGELEY

85 X-3

d. STREET ADDRESS

12 CENTRAL AVE.

e. IS RESIDENCE
ON A FARM?
YES NO

3. NAME OF
DECEASED
(Type or print)

First

Middle

Last

PHILLIPS

NOVEMBER 3

Year
1960

4. DATE
OF
DEATH

Month

Day

Year

5. SEX

6. COLOR OR RACE

7. MARRIED

NEVER MARRIED

8. DATE OF BIRTH

FEMALE

WHITE

WIDOWED

DIVORCED

MARCH 28, 1905

9. AGE (In years
last birthday)
55 yrs.

IF UNDER 1 YEAR

Months

Days

Hours

Min.

10a. USUAL OCCUPATION (Give kind of work done
during most of working life, even if retired)

Spinning employee

10b. KIND OF BUSINESS OR INDUSTRY

Celanese Corp.

11. BIRTHPLACE (State or foreign country)

WEST VIRGINIA

12. CITIZEN OF WHAT COUNTRY?

U. S. A.

13. FATHER'S NAME

EMORY BROWN (DECEASED)

14. MOTHER'S MAIDEN NAME

SARAH TRADER (DECEASED)

15. WAS DECEASED EVER IN U. S. ARMED FORCES?
(Yes, no, or unknown)

No,

16. SOCIAL SECURITY NO.

17. INFORMANT

Address

Ridgeley, W.Va.
Mr. Leslie C. Phillips 12 Central Ave.,

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a)

Maceration of Brain

INTERVAL BETWEEN
ONSET AND DEATH

6 Hrs.

976X
Conditions, if any, which
gave rise to immediate cause
(a), stating the underlying
cause last.

DUE TO

(b)

Gunshot wound of head

6 Hrs.

DUE TO

(c)

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY
PERFORMED?

YES NO

20a. EXTERNAL CAUSE WAS
PRIMARY OR CONTRIBUTING CAUSE OF DEATH.

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

Shot self in head (suicide)

20c. TIME OF INJURY Month, Day, Year

Hour

20d. INJURY OCCURRED

While at work Not while at work

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

Home

20f. (City or town)

Ridgeley

(County)

Mineral

(State)

W.Va.

6:45 p. m. Nov. 3 1960

21. I certify that I took charge of the remains described above, held an Autopsy Inspection Inquiry and find that

death resulted from: Natural causes Accident Suicide Homicide Undetermined cause

ACTUAL
SIGNATURE

EXAMINER'S
NAME (Type)

BENEDICT SKITARELIC, M.D.

M.D. CHIEF MEDICAL EXAMINER

ASSISTANT MEDICAL EXAMINER

DEPUTY MEDICAL EXAMINER

DATE SIGNED

NOVEMBER 3, 1960

22a. BURIAL, CREMATION, REMOVAL (Specify)

Burial

11/5/60

22b. DATE THEREOF

Zion Memorial Cem.

22d. LOCATION (City, town, or county)

Cumberland, Maryland

(State)

23. FUNERAL DIRECTOR'S SIGNATURE

Charles L. George

ADDRESS

Cumberland, Md.

24a. REC'D BY REGISTRAR

NOV 7 '60

DATE

24b. REGISTRAR'S SIGNATURE

Arthur S. Kraus

8. **ANSWER** **QUESTION** **10** **THE** **MAN** **AT** **THE** **DOOR** **IS** **NOT** **ANSWER** **TO** **THE** **QUESTION** **9**.

1
12089 MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
12074
TO HOSPITAL, OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY Allegany		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cumberland		c. LENGTH OF STAY IN 1b 50 yrs	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 34 Race St.		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cumberland	
d. STREET ADDRESS 34 Race St.		d. STREET ADDRESS 34 Race St.	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) Sylvester	First Sylvester	Middle Pittman	Last Pittman
4. DATE OF DEATH Nov. 28, 1960	Month Nov.	Day 28	Year 1960
5. SEX M	6. COLOR OR RACE W	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Nov. 1, 1895
9. AGE (In years last birthday) 65	IF UNDER 1 YEAR Months 0	IF UNDER 24 HRS. Days 0	Hours 0
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Hostler	10b. KIND OF BUSINESS OR INDUSTRY Railroad	11. BIRTHPLACE (State or foreign country) Hancock, Maryland	12. CITIZEN OF WHAT COUNTRY? USA
13. FATHER'S NAME Wallace Pittman	14. MOTHER'S MAIDEN NAME Estella Whisner	Address	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no	16. SOCIAL SECURITY NO. 705-09-9931	17. INFORMANT Mrs. Dora Pittman, Cumberland, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 420.1 Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. (b) DUE TO Coronary Artery disease (c) DUE TO Coronary Artery disease		INTERVAL BETWEEN ONSET AND DEATH immediate	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (o)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		
20c. TIME OF INJURY Hour o. m. p. m.	Month Nov.	Day 19	Year 1960
20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Cumberland, Md.	20f. (City or town) Cumberland	(County) Allegany
		(State) Md.	
21. I certify that I attended the deceased from 11/17/60 , 19, to 11/28/60 , 19, that I last saw the deceased alive on 11/25/60 , 19, and that death occurred at 7:15 P.M. from the causes and on the date stated above.		ADDRESS (Street, city or town, state) Cumberland, Md.	
ACTUAL SIGNATURE <i>James F. Scarcelli</i>	DATE SIGNED 11/28/60		
PHYSICIAN'S NAME (Type)			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 12-1-1960	22c. NAME OF CEMETERY OR CREMATORIUM Hillcrest Burial Park	22d. LOCATION (City, town, or county) Cumberland, Md.
23. FUNERAL DIRECTOR'S SIGNATURE James F. Scarcelli, Cumberland, Md.		ADDRESS	24a. REC'D BY REGISTRAR DATE DEC 5 '60
			24b. REGISTRAR'S SIGNATURE <i>John E. Koenig</i>

CERTIFICATE OF DEATH

T-1519

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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12090 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

12075

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Allegany		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND b. COUNTY Allegany					
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cumberland		c. LENGTH OF STAY IN 1b DOA 02					
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Memorial Hospital		d. STREET ADDRESS 324 Pear Street					
3. NAME OF DECEASED (Type or print) WILLIAM		First DEWEARREN	Middle PORTER				
Last		4. DATE OF DEATH November 14	Month Day Year 1960				
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH March 4, 1890				
9. AGE (In years last birthday) 70 yrs.		10. IF UNDER 1 YEAR Months 0	11. IF UNDER 24 HRS. Days 0				
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired Restaurant Owner		10b. KIND OF BUSINESS OR INDUSTRY Own Business	11. BIRTHPLACE (State or foreign country) Eckhart, Maryland				
12. CITIZEN OF WHAT COUNTRY? USA		13. FATHER'S NAME Josiah Porter					
14. MOTHER'S MAIDEN NAME Helen Wonn		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No					
16. SOCIAL SECURITY NO.		17. INFORMANT Mrs. Annie C. Porter, Cumberland, Maryland	324 ^{Address} Paar Street				
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]							
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CORONARY OCCLUSION							
DUE TO 4201 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) CORONARY SCLEROSIS							
DUE TO (c) -----							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/>				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Hour o. m. p. m.		Month, Day, Year 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)		
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and find that death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/>							
ACTUAL SIGNATURE <i>Benedict Skitarelic</i>				DATE SIGNED M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> NOVEMBER 15, 1960			
EXAMINER'S NAME (Type) BENEDICT SKITARELIC, M.D.		22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Nov. 17, 1960	22c. NAME OF CEMETERY OR CREMATORIAL Frostburg Memorial Park	22d. LOCATION (City, town, or county) Frostburg, Maryland	(State)
23. FUNERAL DIRECTOR'S SIGNATURE John J. Hafer, Cumberland, Maryland		ADDRESS John J. Hafer, Cumberland, Maryland		24a. REC'D BY REGISTRAR NOV 18 '60		24b. REGISTRAR'S SIGNATURE <i>John J. Hafer</i>	

TO DEFENDANT: MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your information.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit Permit. File Pages 1 and 2 with the registrar prior to burial, cremation, or removal.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be signed by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, it should be filed with Page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12076

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Allegany		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Allegany	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cumberland		c. LENGTH OF STAY IN 1b 10 mos. 11 das.	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Sylvan Retreat		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 22 Frostburg	
3. NAME OF DECEASED (Type or print) Urias		d. STREET ADDRESS 148 Ormond Street	
4. DATE OF DEATH Nov 21 1960		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 9/1/78
9. AGE (In years lost birthday) 82 yrs.		10. IF UNDER 1 YEAR Months 0 Days 0 Hours 0 Min. 0	11. IF UNDER 24 HRS. Months 0 Days 0 Hours 0 Min. 0
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Rubber Worker		10b. KIND OF BUSINESS OR INDUSTRY Kelly Springfield	
11. BIRTHPLACE (State or foreign country) Frostburg, Md.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Fredrick Rowe		14. MOTHER'S MAIDEN NAME Sarah Evans	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 214-07-0186	
17. INFORMANT Mr. James R. Rowe, 413 S. Anglesea St., Baltimore 24, Md.		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Myocarditis, Ch. Severe</i> 422.2 DUE TO <i>Psychotic tendencies</i> Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. (b) <i>Secondary anemia, severe</i> DUE TO <i> </i> (c) <i> </i>		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. <i> </i> 19 p. m. <i> </i>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <i>Jan. 10, 1960</i> to <i>Nov. 21, 1960</i> that I last saw the deceased alive on <i>Nov. 21, 1960</i> , and that death occurred at <i>2:25 P.M.</i> from the causes and on the date stated above. ACTUAL SIGNATURE <i>L.B. Matthews, M.D.</i>		ADDRESS (Street, city or town, state) DATE SIGNED <i>14-22-60</i>	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 11-23-60	
22c. NAME OF CEMETERY OR CREMATORIAL Frostburg Memorial Park		22d. LOCATION (City, town, or county) Frostburg (State) Md.	
23. FUNERAL DIRECTOR'S SIGNATURE <i>Hafer Funeral Home</i> <i>Bruce H. Winters, 23 East Main, Frostburg, Md.</i>		24a. REC'D BY REGISTRAR NOV 28 '60	
		24b. REGISTRAR'S SIGNATURE <i>Charles E. Thomas</i>	

STATE OF TEXAS - DEPARTMENT OF HUMAN SERVICES
CERTIFICATE OF DEATH

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4

may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director,
page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with
the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MEDICAL CERTIFICATION

MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND															
12092				ITEMS 8, 9 FILED 12-2-60				12077							
1. PLACE OF DEATH a. COUNTY ALLEGANY				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND				3. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) b. COUNTY ALLEGANY							
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CUMBERLAND				c. LENGTH OF STAY IN 1b 8 DAYS				d. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) RURAL CUMBERLAND							
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION SACRED HEART HOSPITAL				d. STREET ADDRESS R.F.D. #1				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) GIOVINI				First Middle Last GIOVINI SCARINCI				4. DATE OF DEATH NOVEMBER 21 1960							
5. SEX FEMALE		6. COLOR OR RACE WHITE		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>		8. DATE OF BIRTH 1877 FEB. 17, 1877		9. AGE (In years Last birthday) 107 83 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.					
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife				10b. KIND OF BUSINESS OR INDUSTRY Own Home				11. BIRTHPLACE (State or foreign country) Crecchio, Italy				12. CITIZEN OF WHAT COUNTRY? USA			
13. FATHER'S NAME Vincenzo D'Alessandro								14. MOTHER'S MAIDEN NAME Giacinta Scarinci							
15. WAS DECEASED EVER IN U. S. ARMED FORCES? [Yes, no, or unknown] no				16. SOCIAL SECURITY NO. none				17. INFORMANT PATIENTS CHART				Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]															
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 422.02 DUE TO Congestive Heart Failure															
Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. (b) DUE TO Myocardial Degeneration															
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(o)															
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)															
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 20 p. m.															
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) 20d. INJURY OCCURRED While Not while of work <input type="checkbox"/> at work <input type="checkbox"/>															
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)															
21. I certify that (I) (this hospital) attended the deceased from 11/13 1960 to 11/20 1960, that (I) (we) lost saw the deceased alive on 11/20 1960, and that death occurred at M, from the causes and on the date stated above.															
22a. SIGNATURE Leo H. Levy, Jr.															
22c. PHYSICIAN'S NAME (Type) LEO H. LEVY, JR., MD.															
22b. DATE SIGNED 11/21/60															
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial				23b. DATE THEREOF 11-23-60				23c. NAME OF CEMETERY OR CREMATORIAL St. Mary's Cemetery				23d. LOCATION (City, town, or county) Cumberland, Md. (State)			
24. FUNERAL DIRECTOR'S SIGNATURE James F. Scarpelli, Cumberland, Md.															
25a. REG. BY REGISTRAR NOV 28 60 DATE															
25b. REGISTRAR'S SIGNATURE Arthur S. Trahan															

HYACINTHAGRIFFITHS 20051

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

12093

CERTIFICATE OF DEATH

12078

1. PLACE OF DEATH a. COUNTY ALLEGANY		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CUMBERLAND		c. LENGTH OF STAY IN 1b 11 DAYS	
d. NAME OF HOSPITAL OR INSTITUTION MEMORIAL HOSPITAL, MEMORIAL & WARWICK AVES.,		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CUMBERLAND	
3. NAME OF DECEASED (Type or print) First SAMUEL S		d. STREET ADDRESS 30 RACESTREET	
4. DATE OF DEATH NOVEMBER 22 1960		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
5. SEX MALE		6. COLOR OR RACE WHITE	
7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>		8. DATE OF BIRTH AUGUST 16, 1911	
9. AGE (In years last birthday) 49 yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Jockey Agent		10b. KIND OF BUSINESS OR INDUSTRY Race Track	
11. BIRTHPLACE (State or foreign country) COLORADO Trinidad		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME JERRY SCATURRO		14. MOTHER'S MAIDEN NAME PAULINE DARRO	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) yes		16. SOCIAL SECURITY NO. I29-01-6030	
17. INFORMANT MEMORIAL HOSPITAL,		Address CUMBERLAND, MD.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 420 Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. DUE TO <i>Myocardia</i>		INTERVAL BETWEEN ONSET AND DEATH <i>7 days</i>	
(b) <i>Coronary Thrombosis</i> DUE TO <i>Defarction</i> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		12 days	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <i>Oct 15 1960</i> to <i>Nov 22 1960</i> that (I) (we) last saw the deceased alive on <i>Nov. 22 1960</i> and that death occurred <i>8:35 AM</i> from the causes and on the date stated above.		22b. DATE SIGNED	
22a. SIGNATURE <i>Clay E. Durrett</i>		M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>	
22c. PHYSICIAN'S NAME (Type) CLAY E. DURRETT		22d. ADDRESS <i>236 W. 4th Cumberland road</i>	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF II-25-60	
23c. NAME OF CEMETERY OR CREMATORIAL Hillcrest Burial Park		23d. LOCATION (City, town, or county) Cumberland, Md. (State)	
24. FUNERAL DIRECTOR'S SIGNATURE James F. Scarpelli		ADDRESS Cumberland, Md.	
		25a. REC'D BY REGISTRAR DATE NOV 28 '60	
		25b. REGISTRAR'S SIGNATURE Arthur S. Kraus	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

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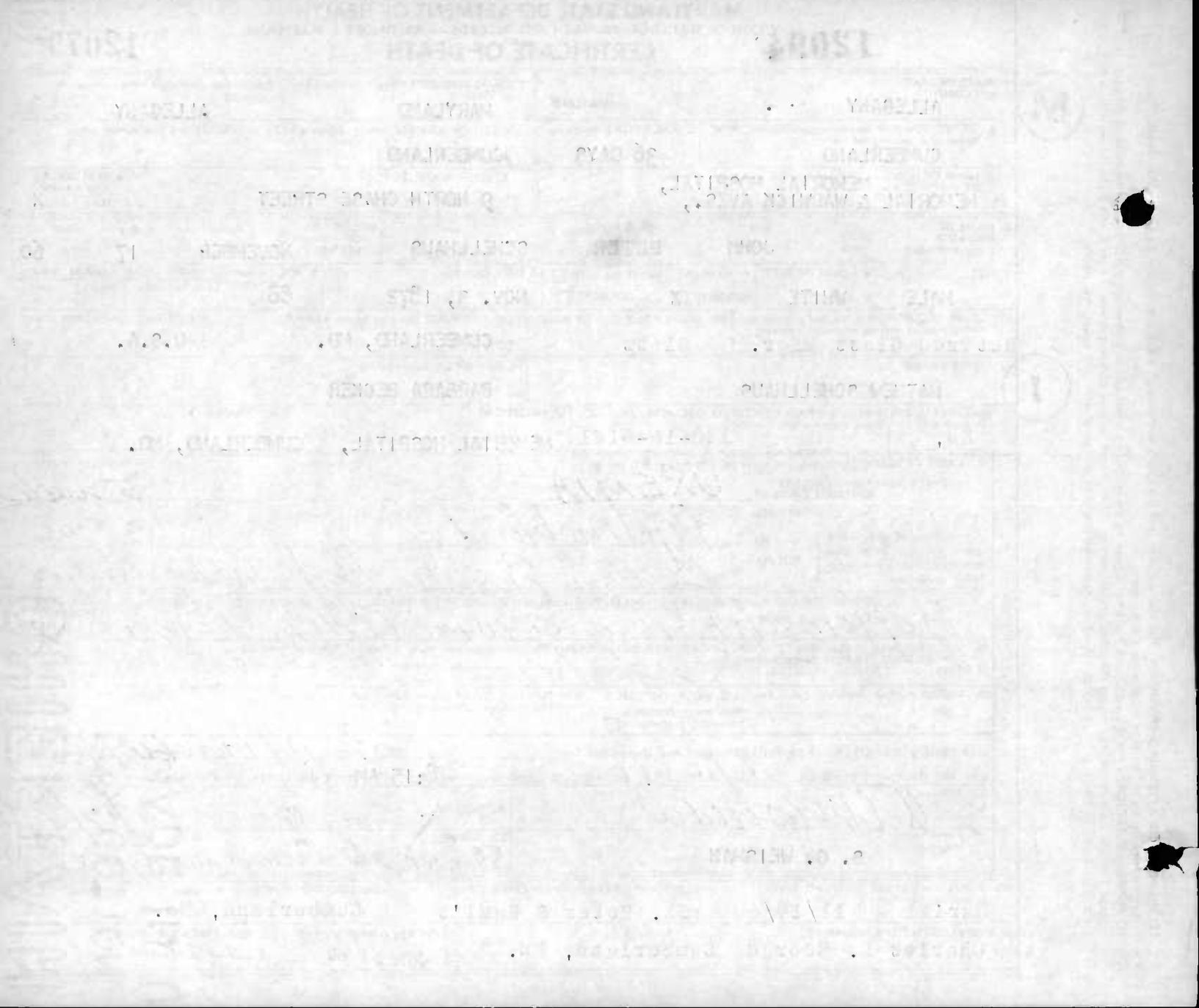
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MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

12094		12079	
<p>1. PLACE OF DEATH a. COUNTY ALLEGANY MARYLAND</p> <p>b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CUMBERLAND</p> <p>c. LENGTH OF STAY IN 1b 36 DAYS</p> <p>d. NAME OF HOSPITAL OR INSTITUTION (If hospital, give address) MEMORIAL HOSPITAL, MEMORIAL & WARWICK AVES.,</p>		<p>2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND b. COUNTY ALLEGANY</p> <p>c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CUMBERLAND</p> <p>d. STREET ADDRESS 9 NORTH CHASE STREET</p> <p>e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/></p>	
<p>3. NAME OF DECEASED (Type or print) First JOHN Middle PETER Last SCHELLHAUS</p> <p>4. DATE OF DEATH NOVEMBER 17 1960</p>		<p>5. SEX MALE 6. COLOR OR RACE WHITE 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> 8. DATE OF BIRTH WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> NOV. 3, 1872 9. AGE (In years from birthday) 88 yrs.</p> <p>10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired Glass Mfgr.</p> <p>10b. KIND OF BUSINESS OR INDUSTRY Glass</p> <p>11. BIRTHPLACE (State or foreign country) CUMBERLAND, MD.</p>	
<p>12. CITIZEN OF WHAT COUNTRY? U.S.A.</p> <p>13. FATHER'S NAME MATHEW SCHELLHAUS</p> <p>14. MOTHER'S MAIDEN NAME BARBARA BECKER</p>		<p>15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No. 16. SOCIAL SECURITY NO. 220-16-6141 17. INFORMANT (If yes, give war or dates of service) MEMORIAL HOSPITAL, CUMBERLAND, MD.</p>	
<p>18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]</p> <p>PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) UREMIA 610X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. (b) Pyelonephritis (c) Benign Prostatic Hyperrophy</p>		<p>INTERVAL BETWEEN ONSET AND DEATH 2 weeks</p> <p>3 years</p> <p>10 yrs</p>	
<p>PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)</p> <p>Neurofibromatosis, general, Cataract, glaucoma</p>		<p>19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/></p>	
<p>20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)</p>		<p>20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Heptosclerosis, general, Cataract, glaucoma</p>	
<p>20c. TIME OF INJURY Month, Day, Year Hour o. m. 19 p. m.</p>		<p>20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/></p>	
<p>20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)</p>		<p>20f. (City or town) CUMBERLAND, MD. (County) MARYLAND (State) MARYLAND</p>	
<p>21. I certify that (I) (this hospital) attended the deceased from 19/11/60 to 11/17/60 that (I) (we) last saw the deceased alive on 11/16/60 and that death occurred 8:15 AM from the causes and on the date stated above.</p>			
<p>22a. SIGNATURE S. G. WEISMAN</p>		<p>M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/></p>	
<p>22c. PHYSICIAN'S NAME (Type) S. G. WEISMAN</p>		<p>22d. ADDRESS 54 Greene St Cumberland, Md.</p>	
<p>23a. BURIAL, CREMATION, REMOVAL (Specify) Burial</p>		<p>23b. DATE THEREOF 11/19/60</p>	
<p>23c. NAME OF CEMETERY OR CREMATORIAL SS. Peter & Paul's</p>		<p>23d. LOCATION (City, town, or county) CUMBERLAND, MD. (State) MARYLAND</p>	
<p>24. FUNERAL DIRECTOR'S SIGNATURE Charles L. George</p>		<p>ADDRESS CUMBERLAND, MD.</p>	
<p>25a. REC'D BY REGISTRAR NOV 21 '60</p>		<p>25b. REGISTRAR'S SIGNATURE Arthur S. Kraus</p>	



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12080

Reg. Dist. No.

12107

CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY Allegany		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE MARYLAND	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Frostburg		c. LENGTH OF STAY IN 1b lifetime	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Miners Hospital		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) FRANK		First EDWARD	Middle EDWARD
4. DATE OF DEATH 11 3 19 60.	Month 11	Day 3	Year 19 60.
5. SEX M	6. COLOR OR RACE W	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH 2-16-1901
9. AGE (In years last birthday) 59 yrs.	10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Textile worker	11. KIND OF BUSINESS OR INDUSTRY Celanese Corp.	12. BIRTHPLACE (State or foreign country) Borden, Md.
13. FATHER'S NAME Alonzo Schriver	14. MOTHER'S MAIDEN NAME Mary Dunn	15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) NO	
16. SOCIAL SECURITY NO. None	17. INFORMANT Margaret B. Schriver, R.D.#2(Borden)	18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Peritonitis Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. 550.0 DUE TO (b) acute ruptured dangerous appendix DUE TO (c)	
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		INTERVAL BETWEEN ONSET AND DEATH 3 days	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour a. m. p. m.	20d. INJURY OCCURRED While at work <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from Oct 28 , 19 60 , to Nov 3 , 19 60 , that I last saw the deceased alive on Nov 3 , 19 60 , and that death occurred at 9:40 A.M. from the causes and on the date stated above.		ADDRESS (Street, city or town, state) Frostburg, Md. DATE SIGNED Nov 4 1960	
ACTUAL SIGNATURE WOMC Lane		PHYSICIAN'S NAME (Type) WOMC Lane MD	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 11/6/60	22c. NAME OF CEMETERY OR CREMATORIAL Frostburg Memorial Park	22d. LOCATION (City, town, or county) Frostburg, Md. (State)
23. FUNERAL DIRECTOR'S SIGNATURE Hafer Funeral Home		24a. ADDRESS 23 E. Main, Frostburg, Md.	24b. REC'D BY REGISTRAR NOV 9 '60
		24b. REGISTRAR'S SIGNATURE Carroll S. Hafer	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death: Page 4
may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
12095 CERTIFICATE OF DEATH 12081

Reg. Dist. No. _____

1. PLACE OF DEATH a. COUNTY Allegany			2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE MARYLAND		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cumberland			c. LENGTH OF STAY IN 1b c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cumberland		
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 11 Frederick St.			d. STREET ADDRESS 11 Frederick St.,		
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print)		First MARY	Middle EDNA	Last SEIFERT	4. DATE OF DEATH Month Nov. Day 10, Year 1960
S. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Aug. 16, 1892	9. AGE (In years less birthday) 88 yrs.	10. IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Store Prop.		10b. KIND OF BUSINESS OR INDUSTRY Furniture	11. BIRTHPLACE (State or foreign country) Mann's Choice, Penna.	12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME John J. Seifert			14. MOTHER'S MAIDEN NAME Laura McVicker		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No,		16. SOCIAL SECURITY NO. 217-10-6865	17. INFORMANT Mr. Mark I. Seifert	Address Cumberland, 11 Frederick St., Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Carcinoma, left colon with INTERVAL BETWEEN DUE TO metastasis to liver and later ONSET AND DEATH 16 months Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. Generalized					
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 1b.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) 232 Balto. Ave. (State) 11/11/60	
21. I certify that I attended the deceased from 30 July , 19 60 , to Nov 9 , 19 60 , that I last saw the deceased alive on 9 Nov , 19 60 , and that death occurred at 2:00 A.M. , from the causes and on the date stated above. ACTUAL SIGNATURE Carlton Brinsfield M.D. ADDRESS (Street, city or town, state) 232 Balto. Ave., DATE SIGNED 11/11/60					
PHYSICIAN'S NAME (Type) Carlton Brinsfield M.D. CUMBERLAND, MD.					
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 11/12/60	22c. NAME OF CEMETERY OR CREMATORIAL Hillcrest Burial Park	22d. LOCATION (City, town, or county) Cumberland, Maryland (State)	
23. FUNERAL DIRECTOR'S SIGNATURE Charles L. George ADDRESS Cumberland, Md.			24a. REC'D BY REGISTRAR DATE NOV 14 '60	24b. REGISTRAR'S SIGNATURE Arthur S. Thrane	

81 ЭКОНОМИКА—ПОДЪЯЧЕВА С.П. ПРОГНОЗИРОВАНИЕ ЭТАПОВ ОБРАЗОВАНИЯ

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be forwarded by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

12096 12082

1. PLACE OF DEATH a. COUNTY ALLEGANY		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CUMBERLAND		b. COUNTY ALLEGANY	
c. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION SACRED HEART HOSPITAL		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 02 CUMBERLAND	
d. STREET ADDRESS 427 BALTIMORE AVE		d. STREET ADDRESS 1	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print)	First HARVEY	Middle Gilbert	Last SHANHOLTZ
4. DATE OF DEATH	Month 11	Day 2	Year 1960
5. SEX MALE	6. COLOR OR RACE WHITE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 2/1/01
9. AGE (In years lost birthday) 56	10. IF UNDER 1 YEAR Months 56	11. IF UNDER 24 HRS. Months 56	12. IF UNDER 24 HRS. Days 56
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Bartender	10b. KIND OF BUSINESS OR INDUSTRY Restaurant	11. BIRTHPLACE (State or foreign country) WEST VIRGINIA	12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME Jacob R. Shanholtz	14. MOTHER'S MAIDEN NAME Nannie V. Day		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No	16. SOCIAL SECURITY NO. 214-05-5231	17. INFORMANT Mr. J. Brooke Shanholtz	Address Cumb. Md. 225 Balto. St.,
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]			
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 157 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) (c)			
INTERVAL BETWEEN ONSET AND DEATH month			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour o. m. p. m.	Month 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from Jan 1960 to Mar 2, 1960 that (I) (we) last saw the deceased alive on Nov 2 1960 , and that death occurred at M , from the causes and on the date stated above.			
22a. SIGNATURE DR. R.M. SCHINDLER		M.D. <input type="checkbox"/> ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>	22b. DATE SIGNED 143/60
22c. PHYSICIAN'S NAME (Type) DR. R.M. SCHINDLER		22d. ADDRESS 43 GREENE STREET	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF 11/5/60	23c. NAME OF CEMETERY OR CREMATORIAL Zion Memorial Cem.	23d. LOCATION (City, town, or county) (State) Cumberland, Maryland
24. FUNERAL DIRECTOR'S SIGNATURE Charles L. George		ADDRESS Cumberland, Md.	25a. REC'D BY REGISTRAR DATE NOV 7 '60
			25b. REGISTRAR'S SIGNATURE Arthur S. Traas

FOR STATE
HEALTH DEPT.

execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File Pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS 115ME
SM 2/57

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12083

12097 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY ALLEGANY		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND		b. COUNTY ALLEGANY		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CUMBERLAND		c. LENGTH OF STAY IN 1b 40 years		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CUMBERLAND		d. STREET ADDRESS 518 FECTIG AVENUE		
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) SACRED HEART--DOA				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
3. NAME OF DECEASED (Type or print) XOXX CARL		First	Middle	Lost	4. DATE OF DEATH NOVEMBER 19, 1960	Month	Doy	Year
5. SEX MALE		6. COLOR OR RACE WHITE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH JULY 30, 1912	9. AGE (In years last birthday) 48	IF UNDER 1 YEAR Months 0	IF UNDER 24 HRS. Days 0	Hours 0
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Station operator		10b. KIND OF BUSINESS OR INDUSTRY Gasoline Station		11. BIRTHPLACE (State or foreign country) MARYLAND		12. CITIZEN OF WHAT COUNTRY? USA		
13. FATHER'S NAME CHARLES SISK				14. MOTHER'S MAIDEN NAME AMANDA DRAKE		Address Cumberland, Md. 306 Bedford St.		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes		16. SOCIAL SECURITY NO. 214 05 6403		17. INFORMANT BROTHER: KEITH SISK		INTERVAL BETWEEN ONSET AND DEATH SUDDEN		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CORONARY SCLEROSIS WITH THROMBOSIS DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. 420.1 (b) ARTERIOSCLEROTIC CARDIOVASCULAR DISEASE DUE TO (c)								
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.								
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)								
20c. TIME OF INJURY Hour o. m. p. m.	Month, Day, Year 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town)	(County)	(State)		
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>								
ACTUAL SIGNATURE <i>W.O. McLane</i>	M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input type="checkbox"/>							DATE SIGNED <i>Nov 19 1960</i>
EXAMINER'S NAME (Type) <i>W.O. McLane MD</i>								
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF Nov. 22, 1960	22c. NAME OF CEMETERY OR CREMATORIAL Rest Lawn Mem. Gardens	22d. LOCATION (City, town, or county) Cumberland, Md.	(State)				
23. FUNERAL DIRECTOR'S SIGNATURE Byron Kight	ADDRESS Cumberland, Md.	24a. REC'D BY REGISTRAR NOV 22 '60	24b. REGISTRAR'S SIGNATURE <i>Arthur S. Trahan</i>					

1 TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be rendered by the hospital or attending physician.

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MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

12084

1. PLACE OF DEATH a. COUNTY ALLEGANY		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) FROSTBURG		c. LENGTH OF STAY IN 1b 48 Hrs.	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION MINERS HOSPITAL		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) FROSTBURG	
3. NAME OF DECEASED (Type or print) ALBERT		d. STREET ADDRESS 133 MAPLE ST.	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		4. DATE OF DEATH Month NOV. Day 1, 19 60	
S. SEX MALE	6. COLOR OR RACE WHITE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH MAY 12, 1895
9. AGE (In years last birthday) 65 yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Oiler-Maintenance	
11. KIND OF BUSINESS OR INDUSTRY KELLY-SPGFD. TIRE		12. BIRTHPLACE (State or foreign country) MARYLAND	
13. FATHER'S NAME WILLIAM SITTIG		14. MOTHER'S MAIDEN NAME MINNIE BRODE	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) 420.1		16. SOCIAL SECURITY NO. 214-01-6244	
17. INFORMANT JAMES SITTIG		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO Coronary Occlusion (b) DUE TO Hypertensive Cardiovascular disease (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)	
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		INTERVAL BETWEEN ONSET AND DEATH 48 hr	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.		20d. INJURY OCCURRED While Not while at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from Nov 1 1960 to Nov 1 1960 that John B. Davis last saw the deceased alive on Nov 1 1960 and that death occurred at 3 AM , from the causes and on the date stated above.		22b. DATE SIGNED	
22a. SIGNATURE John B. Davis		22b. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>	
22c. PHYSICIAN'S NAME (Type) JOHN B. DAVIS, M. D.		22d. ADDRESS 2 BROADWAY, FROSTBURG, MD.	
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b. DATE THEREOF 11-3-60	
23c. NAME OF CEMETERY OR CREMATORIAL F' BG. MEMORIAL PARK		23d. LOCATION (City, town, or county) (State) FROSTBURG, MD.	
24. FUNERAL DIRECTOR'S SIGNATURE L. R. Davis		25a. REC'D BY REGISTRAR DATE NOV 3 '60	
ADDRESS FROSTBURG, MD.		25b. REGISTRAR'S SIGNATURE Arthur S. Davis	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

12085

12098

CERTIFICATE OF DEATH

1. PLACE OF DEATH o. COUNTY ALLEGANY		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE MARYLAND	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CUMBERLAND		c. LENGTH OF STAY IN 1b 10 days	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION SACRED HEART HOSPITAL		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) FLINTSTONE	
3. NAME OF DECEASED (Type or print) LEWIS		First LEWIS	Middle THORNTON
4. DATE OF DEATH Month NOVEMBER	Day 7	Year 1960	
5. SEX MALE	6. COLOR OR RACE WHITE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	B. DATE OF BIRTH Feb. 5, 1892
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) FARMER	10b. KIND OF BUSINESS OR INDUSTRY Own farm	11. BIRTHPLACE (State or foreign country) PA.	12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME JAMES SMITH		14. MOTHER'S MAIDEN NAME ? Sarah Jay	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No	16. SOCIAL SECURITY NO. 2520-4736	17. INFORMANT SON LAWRENCE Smith	Address SAME ADDRESS
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 442 X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c) <i>Old man with cataracts, glaucoma, hypertension, heart disease, cerebral vascular, and dementia - 1 year</i>			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			INTERVAL BETWEEN ONSET AND DEATH 14 days
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour o. m. p. m.	Month, Day 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from 17 Dec 1960 to 7 Nov 1960 , that (I) (we) last saw the deceased alive on 19 Nov 1960 , and that death occurred at 6:30 P.M. from the causes and on the date stated above.			
22a. SIGNATURE David T. Rees		M.D. <input checked="" type="checkbox"/> ATTENDING PHYS. <input type="checkbox"/> 22b. DATE SIGNED 22c. ADDRESS Fairview Cemetery, Cumberland, Md.	MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF Nov. 10, 1960	23c. NAME OF CEMETERY OR CREMATORIAL Fairview Cemetery	24d. LOCATION (City, town, or county) Artemas, Pa.
24. FUNERAL DIRECTOR'S SIGNATURE Byron Kight		ADDRESS Cumberland, Md.	25a. REC'D BY REGISTRAR DATE NOV 14 '60
			25b. REGISTRAR'S SIGNATURE Arthur S. Krause

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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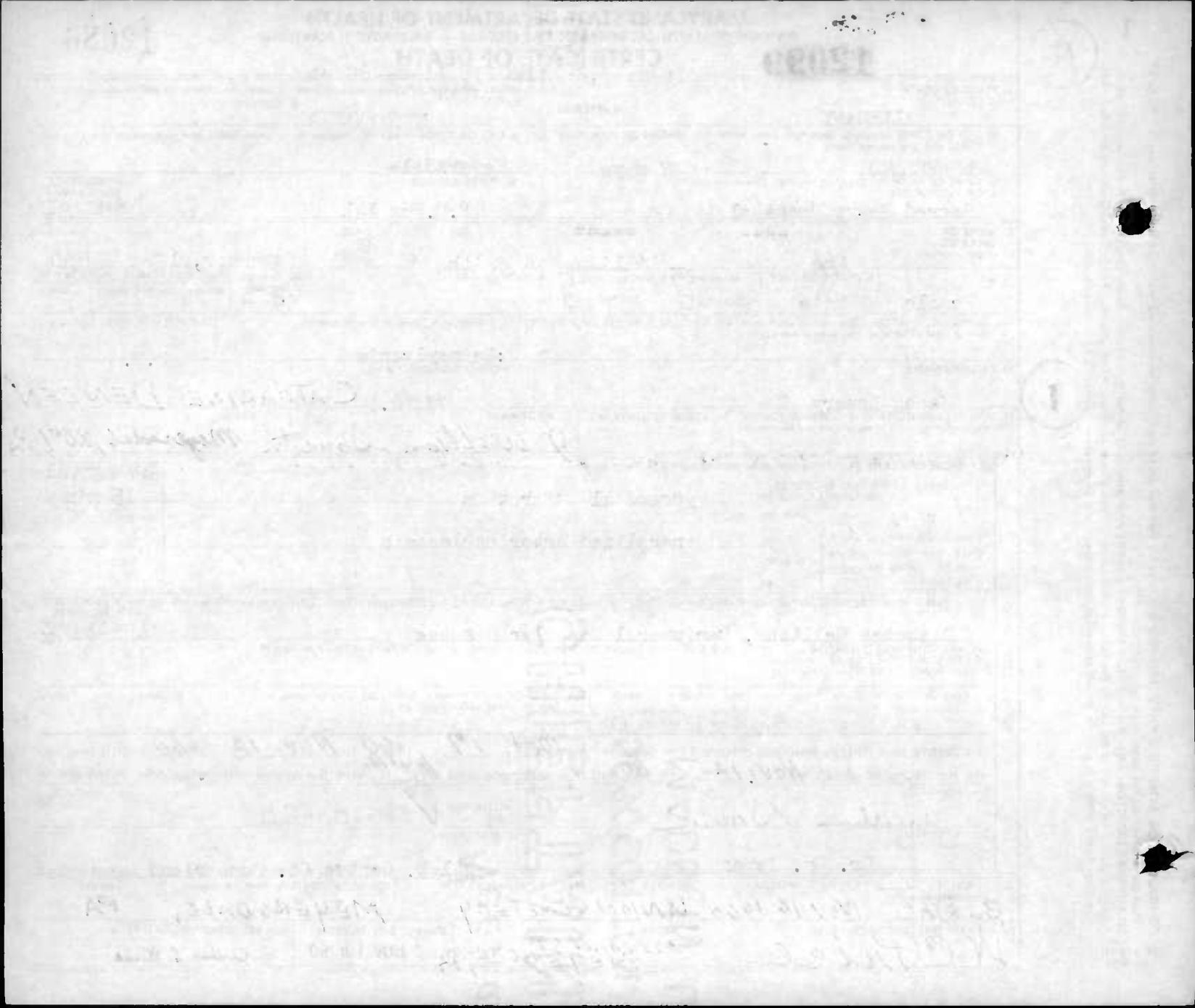
MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

Items 1, 8 Form 0275 11-22-60 et

12086

1. PLACE OF DEATH o. COUNTY ALLEGANY		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE PENNSYLVANIA	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CUMBERLAND		c. LENGTH OF STAY IN lb 27 days		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Meyersdale	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Sacred Heart Hospital		d. STREET ADDRESS P.O. Box 111		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Lillian Mae Smith		4. DATE OF DEATH November, 12 1960		Month Day Year	
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
8. DATE OF BIRTH 1916		9. AGE (In years lost birthday) 65 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY None		11. BIRTHPLACE (State or foreign country) Pennsylvania	
12. CITIZEN OF WHAT COUNTRY? U.S.		13. FATHER'S NAME Jacob Lowery		14. MOTHER'S MAIDEN NAME ??? (D.) CATHARINE DENEEN	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 9 000 000 000		17. INFORMANT William Smith Meyersdale, PA	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]		INTERVAL BETWEEN ONSET AND DEATH			
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 420-1		DUE TO Myocardial Infarction			
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) generalized arteriosclerosis		DUE TO (c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (o)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) Diabetes Mellitus, Peripheral Vascular Disease		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) None	
20f. (City or town) None		(County) None		(State) None	
21. I certify that (I) (this hospital) attended the deceased from Oct. 17 1960 to Nov. 12 1960 that (I) (we) last saw the deceased alive on Nov. 12 1960 and that death occurred at 10:00 A.M. from the causes and on the date stated above.		22b. DATE SIGNED			
22a. SIGNATURE Wm. James		M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>			
22c. PHYSICIAN'S NAME (Type) Dr. Wm. James		22d. ADDRESS 441 N. Centre St., Cumberland			
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b. DATE THEREOF Nov 16, 1960		23c. NAME OF CEMETERY OR CREMATORIAL ADDRESS UNION CEMETERY	
23d. LOCATION (City, town, or county) MEYERSDALE, PA		(State)			
24. FUNERAL DIRECTOR'S SIGNATURE W.C. Price		25a. REC'D BY REGISTRAR NOV 18 '60		25b. REGISTRAR'S SIGNATURE Arthur S. Kraus	



MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

12087

12100

CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY Allegany		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cumberland		c. LENGTH OF STAY IN lb 1b	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Sacred Heart Hospital		e. STREET ADDRESS 135 Pennsylvania Avenue	
3. NAME OF DECEASED (Type or print) Powhatan		First Powhatan	Middle Jefferson
4. DATE OF DEATH 11		Last 17-1889	Month 11
5. SEX Male		6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>
8. DATE OF BIRTH 1-17-1889		9. AGE (In years lost birthday) 71 yrs.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired Carmen		10b. KIND OF BUSINESS OR INDUSTRY Railroad	
11. BIRTHPLACE (State or foreign country) Virginia		12. CITIZEN OF WHAT COUNTRY? Fredericksburg USA	
13. FATHER'S NAME Powhatan Snelling		14. MOTHER'S MAIDEN NAME Sarah Walker	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) yes		16. SOCIAL SECURITY NO. 705-05-8568	
17. INFORMANT Patient's Chart		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Arteriosclerosis, advanced</i> DUE TO 450.0 Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause lost. (b) DUE TO (c)			
INTERVAL BETWEEN ONSET AND DEATH			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Doy. Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 11/17 , 19 60 , to 11/23 , 19 60 , that (I) (we) last saw the deceased alive on 11/23 , 19 60 , and that death occurred at 11:25 M, from the causes and on the date stated above.			
22a. SIGNATURE <i>Leo N. Ley, Jr.</i>		M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>	
22c. PHYSICIAN'S NAME (Type) Dr. L. Ley		22d. ADDRESS 42 N. Centre St.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Cremation		23b. DATE THEREOF II-26-60	
23c. NAME OF CEMETERY OR CREMATORIAL Cedar Hill Crematory		23d. LOCATION (City, town, or county) Washington, D.C. (State)	
24. FUNERAL DIRECTOR'S SIGNATURE James F. Scarpelli		ADDRESS & ARLING NAT Cumberland, Md	
25a. DATE NOV 26 1960		25b. REGISTRAR'S SIGNATURE Arthur S. Trahan	

The ashes buried in Arlington National Cem.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, it may be retained by the hospital or attending physician.
 page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours of death.

1085

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12688

12101

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY ALLEGANY		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND		b. COUNTY ALLEGANY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CUMBERLAND		c. LENGTH OF STAY IN 1b d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 211 WASHINGTON STREET		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CUMBERLAND		d. STREET ADDRESS 211 WASH. CTN STREET			
3. NAME OF DECEASED (Type or print) ANNA		First DICKEY	Middle SPIER	Lost	4. DATE OF DEATH NOV. 19 1960	Month NOV.	Day 19	Year 1960	
5. SEX Female		6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>	8. DATE OF BIRTH March 10, 1881	9. AGE (In years lost birthday) 79 yrs.	IF UNDER 1 YEAR Months	IF UNDER 24 HRS. Days	Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None		10b. KIND OF BUSINESS OR INDUSTRY None		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.			
13. FATHER'S NAME ANDREW SPIER				14. MOTHER'S MAIDEN NAME MARION STEWART					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) NO		16. SOCIAL SECURITY NO. None		17. INFORMANT DR. ALLAN SPIER, BALTIMORE, MARYLAND		Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 171X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause first. (b) DUE TO (c) Carcinoma of Cervix INTERVAL BETWEEN ONSET AND DEATH 3 years									
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) 									
20c. TIME OF INJURY Hour o. m. p. m. 19		Month 19	Day	Year	20d. INJURY OCCURRED While of work <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) Cumberland, Md.	(County) Cumberland, Md.	(State) Md.
21. I certify that I attended the deceased from Aug 1, 1960 , to Nov 18, 1960 , that I last saw the deceased alive on Nov. 18, 1960 , and that death occurred at M , from the causes and on the date stated above. W R Royce Hodges M.D. ACTUAL SIGNATURE ADDRESS (Street, city or town, state) Cumberland, Md. DATE SIGNED 11/21/60									
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Nov. 22, 1960		22c. NAME OF CEMETERY OR CREMATORIUM Rose Hill Cem.		22d. LOCATION (City, town, or county) Cumberland, Md.			
23. FUNERAL DIRECTOR'S SIGNATURE Charles L. George		ADDRESS Cumberland, Md.		24a. REC'D BY REGISTRAR NOV 23 '60		24b. REGISTRAR'S SIGNATURE Orvin S. Kraus			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be signed by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then, please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be signed by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1 MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
12102 CERTIFICATE OF DEATH

12089

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Allegany			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cumberland,			c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 102 Cumberland,		
c. LENGTH OF STAY IN 1b			d. STREET ADDRESS 112 Greene St.,		
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 112 Greene St.,			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print) ALICE ELLEN STANIFORTH			4. DATE OF DEATH Month November Day 24 , Year 1960		
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Aug. 12, 1878	9. AGE (In years last birthday) yrs. 82	10. IF UNDER 1 YEAR Months <input type="checkbox"/> Days <input type="checkbox"/> Hours <input type="checkbox"/> Min. <input type="checkbox"/>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired Clergy			10b. KIND OF BUSINESS OR INDUSTRY Ministry	11. BIRTHPLACE (State or foreign country) Yorkshire, England	
13. FATHER'S NAME Joseph Williams			14. MOTHER'S MAIDEN NAME Elizabeth Nightingale		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. None		17. INFORMANT Mrs. Sadie E. Triplett	
Address Cumberland, Md					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 420.1 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) DUE TO Coronary Thrombosis					
INTERVAL BETWEEN ONSET AND DEATH 6 hours					
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) Coronary Artery Disease					
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from 12-17 , 19 51 , to 11-24 , 19 60 , that I last saw the deceased alive on 11-24 , 19 60 , and that death occurred at 8:45 AM , from the causes and on the date stated above. ACTUAL SIGNATURE W. F. Williams M.D. ADDRESS (Street, city or town, state) 122 So. Centre St., Cumberland, Md. DATE SIGNED 11/28/60					
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 11/27/60	22c. NAME OF CEMETERY OR CREMATORIAL Hillcrest Burial Park	22d. LOCATION (City, town, or county) (State) Cumberland, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE Charles L. George			ADDRESS Cumberland, Md.	24a. REC'D. BY REGISTRAR NOV 28 '60	24b. REGISTRAR'S SIGNATURE Arthur S. [Signature]

1
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
 DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

12109

CERTIFICATE OF DEATH

12090

1. PLACE OF DEATH o. COUNTY Allegany		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE MARYLAND	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Frostburg		c. LENGTH OF STAY IN lb X	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Miners Hospital		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Lonaconing	
d. STREET ADDRESS St. Marys Terrace		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print)	First Peter	Middle Staup	4. DATE OF DEATH November 20 1960
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH September 20, 1873
9. AGE (In years last birthday) 87 yrs.		10. IF UNDER 1 YEAR Months 0 Days 0	11. IF UNDER 24 HRS. Hours 0 Min. 0
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired Farmer		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) Lonaconing, Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME George Staup		14. MOTHER'S MAIDEN NAME Rebecca Miller	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. 17. INFORMANT Mrs. Albert Grindel	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 4501 Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause first. (b) DUE TO (c) DUE TO PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		Address Lonaconing, Md. INTERVAL BETWEEN ONSET AND DEATH 48 hours	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While Not while at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from May 2 1957 to Nov 26 1960 that (I) (we) last saw the deceased alive on Nov 20 1960 , and that death occurred at 3 P.M. from the causes and on the date stated above.		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
22c. SIGNATURE 		22b. DATE SIGNED 11-21-60	
22c. PHYSICIAN'S NAME (Type) L.R. MILES, JR., M.D.		22d. ADDRESS LONACONING, MARYLAND	
23a. BURIAL, CREMATION, Burial (specify)		23b. DATE THEREOF 11/23/60	
23c. NAME OF CEMETERY OR CREMATORIAL Oak Hill Cemetery		23d. LOCATION (City, town, or county) Lonaconing, Md. (State)	
24. FUNERAL DIRECTOR'S SIGNATURE George Eichhorn		ADDRESS Lonaconing, Md.	
25a. REC'D BY REGISTRAR DATE NOV 22 '60		25b. REGISTRAR'S SIGNATURE Arthur S. Evans	

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12103

CERTIFICATE OF DEATH

Reg. Dist. No.

12091

1. PLACE OF DEATH a. COUNTY Allegany		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland		b. COUNTY Allegany				
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cumberland		c. LENGTH OF STAY IN 1b Lifetime		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cumberland		d. STREET ADDRESS 20 W. Second Street				
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 20 W. Second Street		d. STREET ADDRESS 20 W. Second Street		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>						
3. NAME OF DECEASED (Type or print) Agnes Rachel Stickley		First Agnes	Middle Rachel	Last Stickley	4. DATE OF DEATH Nov. 6.	Month Nov.	Day 6	Year 1960		
5. SEX F	6. COLOR OR RACE W	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH June 8, 1879		9. AGE (In years last birthday) 81 yrs.	10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		11. KIND OF BUSINESS OR INDUSTRY Ownhome	12. BIRTHPLACE (State or foreign country) Cumberland, Md.	13. CITIZEN OF WHAT COUNTRY? USA
14. FATHER'S NAME James H. House		15. MOTHER'S MAIDEN NAME Sarah C. Hamilton		16. SOCIAL SECURITY NO. None		17. INFORMANT Nellie Randall 20 W. Second St.	Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 422.1 Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause lost. (b) DUE TO		19. INTERVAL BETWEEN ONSET AND DEATH <i>Myocarditis</i> <i>Arteriosclerosis</i> <i>2 yrs.</i>								
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)	19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21. I certify that I attended the deceased from Jan. 5 to Nov. 6 , 1960, that I last saw the deceased alive on Nov. 4 , 1960, and that death occurred at 10: P.M. from the causes and on the date stated above.		ACTUAL SIGNATURE <i>Clay E. Durrett</i>		PHYSICIAN'S NAME (Type) Clay E. Durrett		ADDRESS (Street, city or town, state) 236 W. 4th Cumberland, Md.		DATE SIGNED 1/7/60		
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 11-9-60		22c. NAME OF CEMETERY OR CREMATORIUM Greenmount Cem.		22d. LOCATION (City, town, or county) Cumberland, Md.		(State)		
23. FUNERAL DIRECTOR'S SIGNATURE James F. Scarpelli		ADDRESS Cumberland, Md.		24a. REC'D BY REGISTRAR DATE NOV 9 '60		24b. REGISTRAR'S SIGNATURE Arthur S. King				

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be signed by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 10/57

MARYLAND STATE DEPARTMENT OF HEALTH
 DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

12092

12104

1. PLACE OF DEATH o. COUNTY ALLEGANY		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE MARYLAND	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CUMBERLAND		c. LENGTH OF STAY IN 1b 15 DAYS	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION SACRED HEART HOSPITAL		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CUMBERLAND	
d. STREET ADDRESS 998 MCMULLEN HIGHWAY		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) RUTH		First RUTH	Middle A.
3. NAME OF DECEASED (Type or print) RUTH		Last STUMP	4. DATE OF DEATH NOVEMBER 9 1960
5. SEX FEMALE		6. COLOR OR RACE WHITE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>
8. DATE OF BIRTH JAN. 16, 1935		9. AGE (In years from birthday) 25 yrs.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE & Clerk		10b. KIND OF BUSINESS OR INDUSTRY Dry Cleaning Station	
10c. BIRTHPLACE (State or foreign country) WEST VIRGINIA		11. CITIZEN OF WHAT COUNTRY? Grafton USA	
13. FATHER'S NAME WILLIAM CLINGAN (DECEASED)		14. MOTHER'S MAIDEN NAME CLARA Kline	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 234-54-4380	
17. INFORMANT PATIENTS CHART		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Diabetic Coma	
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Diabetes mellitus		DUE TO INTERVAL BETWEEN ONSET AND DEATH 4 days	
DUE TO (c)		12 years	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(o) Gangrene, right foot. Spontaneous abortion of pregnancy			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Doy, Year Hour a. m. 19 p. m.		20d. INJURY OCCURRED While <input type="checkbox"/> Nat while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 11-5 1956 to 11-9 1960 , that (I) (we) last saw the deceased alive on 11-8 1960 , and that death occurred on 11-9 1960 at 1:05 P.M. from the causes and on the date stated above.			
22a. SIGNATURE <i>Ralph W. Ballin</i>		M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> A.M. MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> 22b. DATE SIGNED	
22c. PHYSICIAN'S NAME (Type) RALPH W. BALLIN, M.D.		22d. ADDRESS 62 GREENE ST., CUMBERLAND, MD. 11-9-60	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF II-12-60	
23c. NAME OF CEMETERY OR CREMATORIAL Hillcrest Burial Park		23d. LOCATION (City, town, or county) Cumberland, Md.	
24. FUNERAL DIRECTOR'S SIGNATURE James F. Scarpelli		ADDRESS Cumberland, Md.	25a. REC'D BY REGISTRAR DATE NOV 14 '60
		25b. REGISTRAR'S SIGNATURE <i>Arthur S. Kraus</i>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4
 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director,
 page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with
 the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

